

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03089

3095

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                           |   |                               |   |                           |  |               |
|--|---------------------------|---|-------------------------------|---|---------------------------|--|---------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                           | MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br>Maryland |                           | b. COUNTY<br>Frederick   |               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                           | c. LENGTH OF STAY IN lb<br>1 day  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X Rural Middletown        |                           |  |               |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Frederick Memorial Hospital   |                           | d. STREET ADDRESS   |                               |   |                           | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |               |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br>Alice            | Middle<br>M. Ausherman  | Lost                          | 4. DATE<br>OF<br>DEATH<br>3   | Month<br>Month            | Day<br>18  | Year<br>19 59 |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>4/20/1866 | 9. AGE (In years<br>last birthday<br>92 yrs.)   | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HRS.<br>Days   | Hours Min.    |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>housewife  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home   |                               | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.   |               |
| 13. FATHER'S NAME<br>Daniel Gaylor   |                           | 14. MOTHER'S MAIDEN NAME<br>Mary Flook  |                               |   |                           |  |               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown)<br>no   |                           | 16. SOCIAL SECURITY NO.<br>none   |                               | 17. INFORMANT<br>Mrs. Harry Sowers, Burkittsville, Md.  |                           | Address  |               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>420.1  |                           | Cerebral thrombosis   |                               | INTERVAL BETWEEN<br>ONSET AND DEATH<br>10 days  |                           |  |               |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)<br>DUE TO  |                           | Coronary artery - sclerotic C. V. D.<br>(c)   |                               | 3 years   |                           |  |               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |                               |   |                           | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               |   |                           |  |               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour<br>o. m.<br>p. m.   |                           | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>M.D.                             |                           | 20f. (City or town)<br>(County) (State)  |               |
| 21. I certify that I attended the deceased from <u>March 13, 1959</u> , to <u>March 15, 1959</u> , that I last saw the deceased<br>alive on <u>March 15, 1959</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE <u>B. O. Thomas Jr.</u> |                           |   |                               | ADDRESS (Street, city or town, state)<br><u>228 N Market St. Frederick, Md.</u>                               |                           | DATE SIGNED<br><u>March 16, 1959</u>   |               |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |                           | 22b. DATE THEREOF<br>3/18/1959  |                               | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Ch. of God Cemetery   |                           | 22d. LOCATION (City, town, or county) (State)<br>Locust Valley, Fred. Co, Md.                        |               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Gladhill Company, Middletown, Md.  |                           | ADDRESS   |                               | 24a. REC'D BY REGISTRAR<br>DATE MAR 20 '59  |                           | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Keane</u>   |               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3096

## CERTIFICATE OF DEATH

03090

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>FREDERICK</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FREDERICK</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>Approx. 15 yrs.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X RIDGEVILLE MARYLAND</b>  |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>JOSEPH</b>  |                                  | First<br><b>EDWARD</b>  | Middle<br><b>BEATTY</b>   |
| 4. DATE<br>OF<br>DEATH<br><b>MARCH 8, 1959.</b>   |                                  | Last<br><b>12/29/1873</b>   | Month<br>Year<br>Day<br>Year  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/29/1873</b>   |
| 9. AGE (In years<br>lost birthday)<br><b>85 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Telegraph Operator</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O. R.R. Co.</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Frederick County Md.</b>  |
| 13. FATHER'S NAME<br><b>Wm. H.T. Beatty</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie M. Nusz</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>705-07-7959</b>   | 17. INFORMANT<br><b>Eddie L. Beatty, 114 Cedarcroft Rd, Balto, Md.</b>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0 Congestive Heart Failure</b>                     |                                  | 19. INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>1 wk</b>  |   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause, lost.<br>(b)<br><b>Arterosclerotic Heart Disease</b>                                     |                                  | 20. DUE TO<br><b>10 years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Bronchopneumonia bilateral.</b>                        |                                  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.  | Month<br><b>19</b>               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |
| 21. I certify that I attended the deceased from<br>alive on <b>3/8, 1959</b> , to <b>3/8, 1959</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above. |                                  | ADDRESS (Street, city or town, state)<br><b>Henry V. Chase</b> M.D.   |   |
| ACTUAL<br>SIGNATURE<br><b>Henry V. Chase</b>  |                                  | DATE SIGNED   |   |
| PHYSICIAN'S<br>NAME (Type)<br><b>HENRY V. CHASE, MD.</b>  |                                  | 4, East Church St. Frederick Md.  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 22b. DATE THEREOF<br><b>3/11/59</b>   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>PINE GROVE CEMETERY</b>  |
| 22d. LOCATION (City, town, or county)<br><b>MT AIRY</b>   |                                  | (State)<br><b>Maryland</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert S. Dailey Jr.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Arthur S. Kraus</b>   | 24b. REGISTRAR'S SIGNATURE  |
| ADDRESS<br><b>FREDERICK, Md.</b>  |                                  | DATE<br><b>MAR 12 '59</b>   |   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3097

## CERTIFICATE OF DEATH

03091

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Frederick</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>MARYLAND</b>     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL</b><br><b>Frederick</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Maryland</b>                      |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br><b>Frederick</b> |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>Sarah</b>  |  | First<br><b>Elizabeth</b>  | Middle<br><b>Boone</b>   |
| 4. DATE<br>OF<br>DEATH<br><b>March 20</b>  | Month<br><b>19 59</b>  | Day  | Year   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>                                     | 7. MARRIED <input checked="" type="checkbox"/> NEVER <input type="checkbox"/> MARRIED<br><b>Never married</b>            | B. DATE OF BIRTH<br><b>Aug. 12-1881</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 10c. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Charles Francis Joseph Nusbaum</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Elizabeth Burrier</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>215-18-2219</b>   |  |
| 17. INFORMANT<br><b>Norman E. Boone</b>  |  | Address<br><b>18 Gyro Drive-Balto. 20-Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br><b>422.1</b>   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>4 day</b>  |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (o), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br><b>Cerebral hemorrhage</b>   |  | 10 year  |  |
| (c)<br>DUE TO<br><b>Arteriosclerotic cardiovascular disease</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)<br><b>Acute pyelonephritis</b>  |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                             |  |
| 20c. TIME OF INJURY<br>Hour<br>o. p.<br>p. m.  | Month<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |
| 21. I certify that I attended the deceased from <b>16 March, 1959</b> , to <b>20 March, 1959</b> , that I last saw the deceased alive on <b>20 March, 1959</b> , and that death occurred at <b>45A M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>WALKERSVILLE, Md</b> DATE SIGNED<br><b>3/21/59</b> |  |  |  |
| ACTUAL<br>SIGNATURE<br><i>James S. Stoner Jr.</i>  | M.D.   |  |  |
| PHYSICIAN'S<br>NAME (Type)<br><b>JAMES S. STONER, JR</b>   | 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>        |  |  |
| 22b. DATE THEREOF<br><b>3-23-1959</b>  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Union Chapel Cemetery</b> | 22d. LOCATION (City, town, or county)<br><b>Nr. Libertytown - Maryland</b>   | (State)  |
| 23. DATE OF FUNERAL HOME.<br><i>Frederick</i>  | ADDRESS<br><b>Frederick-Maryland</b>                                 | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 24 '59</b>   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Knobell</i>   |

ВІД ЕКОНОМІКА-ІНДУСТРІАЛІСТІВ ОДИНСТВО ВУДОВІ ОДИІВ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG239 3-16-59 et

3128

## CERTIFICATE OF DEATH

03092

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |   |  |   |   |                          |   |
|---|--|--|---|--|---|---|--------------------------|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>  |  | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>Maryland</i> |   | b. COUNTY<br><i>Frederick</i>   |                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rte 7, Frederick</i>   |  | c. LENGTH OF STAY IN 1b<br><i>5 yrs</i>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Buckeystown</i>               |   | d. STREET ADDRESS<br><i>P. O. Box 66</i>  |                          |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Frederick County Chronic Hospital</i>  |  |  |   | d. STREET ADDRESS<br><i>P. O. Box 66</i>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                          |   |
| 3. NAME OF DECEASED (Type or print)<br><i>John Howard Brown</i>   |  | First  | Middle  | Last   | 4. DATE OF DEATH<br>3 4 1959                      | Month   | Day                      | Year  |
| 5. SEX<br><i>m.</i>   |  | 6. COLOR OR RACE<br><i>c.</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH<br><i>MAR. 12-1882</i>  | 9. AGE (In years last birthday)<br><i>76 yrs.</i> | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days | Hours                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Furniture warehouse - Packer</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Montgomery Co. Md</i>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>Ruth Crawford R.R. Subt. Frederick County, Md</i>              |                          |   |
| 13. FATHER'S NAME<br><i>Richard Brown</i>   |  | 14. MOTHER'S MAIDEN NAME<br><i>Amelia Brown</i>  |   |  |   |   |                          |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |   | Address   |                          |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>331X</i>  |  | DUE TO<br><i>Cerebral Hemorrhage</i>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>5-4-15</i>  |   |   |                          |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><i>Arteriosclerosis</i>  |  | (c)  |   |  |   | <i>5 yrs.</i>   |                          |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)                         |   |  |   |   |                          |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <i>19</i> p. m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town)<br><i>Maryland</i>  |                          | (County) <i>Maryland</i> (State) <i>Md.</i> |
| 21. I certify that I attended the deceased from _____, 1956, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at 10145AM, from the causes and on the date stated above. |  |  |   | ADDRESS (Street, city or town, state)<br><i>7 N. Market St. Frederick Md.</i>  |   | DATE SIGNED<br><i>May 4 59</i>  |                          |   |
| ACTUAL SIGNATURE<br><i>H. F. Kline</i>  |  | M.D.   |   |  |   |   |                          |   |
| PHYSICIAN'S NAME (Type)<br><i>Dr. H. F. Kline</i>   |  |  |   |  |   |   |                          |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |  | 22b. DATE THEREOF<br><i>3-4-59</i>   |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>FAIRVIEW</i>  |   | 22d. LOCATION (City, town, or county)<br><i>Frederick - Md.</i>                                   |                          | (State)                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>CHARLES E. HICKS</i>   |  | ADDRESS<br><i>Frederick-Md.</i>  |   | 24a. REC'D BY REGISTRAR<br>DATE<br><i>MAR 1 0 '59</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Thomas</i>   |                          |   |

## CERTIFICATE OF DEATH

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |    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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 11 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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FOR STATE,  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03093

Reg. Dist. No.

3098

|  |                           |   |                                |  |   |   |  |
|--|---------------------------|---|--------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                           | MARYLAND  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE Maryland |   | b. COUNTY Frederick                           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                           | c. LENGTH OF STAY IN lb<br>1 day  |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Knoxville        |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Memorial Hospital  |                           | d. STREET ADDRESS<br>New Addition   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) Joseph Thomas Carey   |                           | First   | Middle                         | 4. DATE OF DEATH<br>Carey  | 3 Month 19 Doy Year                       | 1959  |  |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           | B. DATE OF BIRTH<br>11-13-1921 | 9. AGE (In years<br>from birthday)<br>37 yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Day  |                                | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.        |  |
| 13. FATHER'S NAME<br>Joseph F. Carey   |                           | 14. MOTHER'S MAIDEN NAME<br>Marion H. Carter  |                                |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                           | 16. SOCIAL SECURITY NO.<br>220-06-6717  |                                | 17. INFORMANT<br>Mrs. Marion Carey, Knoxville, Md.   |   | Address                                       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |                           | General pectoralitis  |                                | INTERVAL BETWEEN<br>ONSET AND DEATH<br>24 hrs  |   |   |  |
| 541.1<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.   |                           | DUE TO<br>(b)<br>Ruptured cerebral vessel   |                                | 24 hrs   |   |   |  |
| DUE TO<br>(c)  |                           |   |                                |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           |   |                                |  |   |   |  |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |                                | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>o. m.<br>p. m.  |                           | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                     |   | 20f. (City or town)<br>(County) (State)       |  |
| 19   |                           |   |                                |  |   |   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |                                |  |   |   |  |
| ACTUAL<br>SIGNATURE<br>B. O. Thomas  |                           | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED<br>3-19-1959                      |  |
| EXAMINER'S<br>NAME (Type)  |                           | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Brethren  |                                | 22d. LOCATION (City, town, or county)<br>Brownsville, Maryland   |   | (State)                                       |  |
| 22a. BURIAL, CREMATION, OR<br>REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>3-22-1959  |                                | 24a. REC'D BY REGISTRAR<br>MAR 24 '59  |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>B. O. Felt   |                           | ADDRESS<br>Brunswick, Maryland  |                                | DATE   |   |   |  |
|  |                           |   |                                |  |   |   |  |

BY THE DEPARTMENT OF STATE  
OF EXAMINERS OF DOCUMENTS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03094

3099

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Days</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |  | b. COUNTY<br><b>Maryland</b>                         |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |  | d. STREET ADDRESS<br><b>1033 North Market Street</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>ADA</b>  |  | First<br><b>M.</b>   |  | Middle<br><b>CONARD</b>   |  | 4. DATE<br>OF<br>DEATH<br><b>March 7, 1959</b>   |  | Month<br>Year  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 22, 1879</b>   |  | 9. AGE (In years<br>last birthday)<br><b>79</b> yrs. |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired- Clerk</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Store</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Joseph F. Conard</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Miller</b>   |  |   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Mrs. Bernard Spring; Frederick, Maryland</b>  |  | 1033 North Market St.  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b>  |  | DUE TO<br><b>Cerebral Hemorrhage</b>   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>4 days</b>  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Arterio-Sclerosis</b>  |  | DUE TO<br>(c)  |  | ( <b>?</b> )  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes mellitus</b>   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>June 1958</b> to <b>7 March 1959</b> , that I last saw the deceased alive on <b>6 March 1959</b> , and that death occurred at <b>9:30A.M.</b> from the causes and on the date stated above. |  |  |  | ADDRESS (Street, city or town, state)<br><b>Professional Building</b>   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles H. Conley M.D.</b>  |  |  |  | DATE SIGNED<br><b>3/7/59</b>  |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Charles H. Conley</b>  |  | Frederick, Maryland  |  |   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3/9/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Union Cemetery</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Lovettsville, Virginia</b> (State)                                       |  |  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son</b>  |  | ADDRESS<br><b>Frederick, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>Arthur S. Krause</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>  |  |  |  |  |  |
| VS A15 (4)<br>1SM 10/57  |  | DATE<br><b>Mar. 9 '59</b>  |  |   |  |  |  |  |  |  |  |

81. 2000-12-28-01-14-00 STATE CHARTER  
- 2000-12-28-01-14-00 STATE CHARTER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

Item 18 Film 240 4-6-59 aus MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

3125

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>  |  | c. LENGTH OF STAY IN lb<br><b>7 months</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>35 Brunswick</b>   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>501 Walnut Street</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Ronnie Lee</b>  |  | f. STREET ADDRESS<br><b>Conner</b>  |  |
| 4. DATE OF DEATH<br><b>March 25 1959</b>  |  | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 5. SEX<br><b>Male</b>   |  | h. COLOR OR RACE<br><b>White</b>  |  |
| i. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   |  | j. DATE OF BIRTH<br><b>August 8, 1958</b>   |  |
| k. AGE (In years, last birthday)<br><b>7 yrs.</b>   |  | l. IF UNDER 1 YEAR<br><b>Months 7 Days 17</b>   |  |
| m. IF UNDER 24 HRS.<br><b>Hours 17</b>  |  | n. IF UNDER 24 HRS.<br><b>Hours 17</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Henry Lee Conner</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Henry Lee Conner</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Dorothy Roberson</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Address</b>   |  |
| 17. INFORMANT<br><b>Henry Lee Conner, Brunswick, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |   |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>492X</b> DUE TO <b>Congestive Cardiac failure</b> INTERVAL BETWEEN ONSET AND DEATH Hour  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (b) <b>Viral pneumonia</b> 3 days?   |  |   |  |
| DUE TO (c)  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.<br>19   |  | 20d. INJURY OCCURRED<br>White<br>at work <input type="checkbox"/> Not white<br>at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>B.O. Thomas</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED<br><b>March 25, 1959</b> |  |
| EXAMINER'S NAME (Type)<br><b>B.O. Thomas, M.D.</b>  |  | 22b. DATE THEREOF<br><b>3-28-1959</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS<br><b>Park Heights</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Brunswick, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE MAR 30 '59  |  |
|   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |

STATE OF  
NEW YORK

EDUCATIONAL EXAMINERS' CREDENTIALS

STATE OF NEW YORK

EDUCATIONAL EXAMINERS' CREDENTIALS

STATE OF  
NEW YORK

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3129

## CERTIFICATE OF DEATH

03096

Reg. Dist. No.

|   |                                  |  |                                      |  |                                     |  |                               |                              |
|---|----------------------------------|--|--------------------------------------|--|-------------------------------------|--|-------------------------------|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |                                  | MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b> |                                     | b. COUNTY<br><b>Frederick</b>  |                               |                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Knoxville</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>life</b>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Knoxville</b>                 |                                     | d. STREET ADDRESS  |                               |                              |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |  |                                      | d. STREET ADDRESS  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |                              |
| 3. NAME OF DECEASED (Type or print)<br><b>Dennis R. Cooper</b>  |                                  | First  | Middle                               | Last   | 4. DATE OF DEATH<br><b>3 1 1959</b> | Month  | Day                           | Year                         |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>3/27/1876</b> | 9. AGE (In years last birthday)<br><b>82 yrs.</b>  | 10. IF UNDER 1 YEAR<br>Months       | 11. IF UNDER 24 HRS.<br>Days   | 12. IF UNDER 24 HRS.<br>Hours | 13. IF UNDER 24 HRS.<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>conductor</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>railroad</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                               |                              |
| 13. FATHER'S NAME<br><b>William Cooper</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth ?</b>   |                                      |  |                                     |  |                               |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>705-09-2859</b>  |                                      | 17. INFORMANT<br><b>Jesse Rohrbach, Knoxville, Md.</b>   |                                     | Address  |                               |                              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b>   |                                  | DUE TO<br><b>Cerebral accident</b>   |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos.</b>  |                                     |  |                               |                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><b>arterio-Sclerosis</b>   |                                  | (c)  |                                      | (d)<br><b>10 yrs.</b>  |                                     |  |                               |                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |                                     |  |                               |                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |  |                                     |  |                               |                              |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)    |                                     |  |                               |                              |
| 21. I certify that I attended the deceased from <b>12/18</b> , 19 <b>57</b> to <b>3/1</b> , 19 <b>59</b> that I last saw the deceased alive on <b>2/26</b> , 19 <b>59</b> , and that death occurred at <b>2 A. M.</b> from the causes and on the date stated above. |                                  |  |                                      | ADDRESS (Street, city or town, state)<br><b>Brunswick, Md.</b>   |                                     | DATE SIGNED<br><b>3/2/59</b>   |                               |                              |
| ACTUAL SIGNATURE<br><b>W. B. Carpenter</b>  |                                  | PHYSICIAN'S NAME (Type)<br><b>Dr. W. B. Carpenter</b>  |                                      |  |                                     |  |                               |                              |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 22b. DATE THEREOF<br><b>3/4/1959</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Knoxville Cemetery</b>  |                                     | 22d. LOCATION (City, town, or county)<br><b>Knoxville, Md.</b>                                 |                               |                              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gladhill company, Middletown, Md.</b>  |                                  | ADDRESS  |                                      | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 6 '59</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thrus</b>   |                               |                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Cause of Death

Date of Death

Place of Death

Name of Physician

Name of Hospital

Name of Doctor

Name

Address

City

State

Zip

Phone

Social Security

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Doctor

Name of Hospital

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Doctor

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3100

## CERTIFICATE OF DEATH

03097

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the physician. After this certificate has been signed by the attending physician and completely filled in by the physician, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                       |  |                                 |   |                                |  |                      |
|---|-----------------------|--|---------------------------------|---|--------------------------------|--|----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |                       | MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |                                | b. COUNTY<br>Frederick   |                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick   |                       | c. LENGTH OF STAY IN 1b<br>1 day   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X Bartonsville            |                                | d. STREET ADDRESS  |                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Frederick Memorial Hospital  |                       |  |                                 |   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |
| 3. NAME OF DECEASED<br>(Type or print)  | First<br>Edith        | Middle<br>I Lillian  | Last<br>Davis                   | 4. DATE OF DEATH  | Month<br>3                     | Day<br>5   | Year<br>19 59        |
| 5. SEX<br>F   | 6. COLOR OR RACE<br>C | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 7. DATE OF BIRTH<br>11-28- 1888 | 9. AGE (In years<br>lost birthday)<br>70 yrs.   | IF UNDER 1 YEAR<br>Months<br>0 | IF UNDER 24 HRS.<br>Days<br>0  | Hours<br>0 Min.<br>0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Domestic   |                       | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country)<br>Frederick Co Md  |                                | 12. CITIZEN OF WHAT COUNTRY?   |                      |
| 13. FATHER'S NAME<br>John Thomas Hill   |                       | 14. MOTHER'S MAIDEN NAME<br>Sarah Elizabeth Tyler  |                                 |   |                                |  |                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                       | 16. SOCIAL SECURITY NO.<br>214-10-3872D  |                                 | INFORMANT<br>Ulysses M. Davis   |                                | Address<br>Bartonsville, Md  |                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute Cardiac Congestive</i> DUE TO <i>422.1</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardo-vascular disease</i> DUE TO <i>5 yrs +</i> (c) |                       |  |                                 |   |                                |  |                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                       |  |                                 |   |                                |  |                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                 |   |                                |  |                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19 p. m.   |                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                | 20f. (City or town) (County) (State)   |                      |
| 21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>59</i> , to <i>March 5, 1959</i> that I last saw the deceased alive on <i>March 5, 1959</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <i>Bartonsville, Md</i> DATE SIGNED <i>March 7, 1959</i>                                       |                       |  |                                 |   |                                |  |                      |
| ACTUAL SIGNATURE<br><i>B. D. Thomas</i>   |                       | M.D.   |                                 |   |                                |  |                      |
| PHYSICIAN'S NAME (Type)<br><i>B. D. Thomas</i>  |                       |  |                                 |   |                                |  |                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                       | 22b. DATE THEREOF<br>3-9-59  |                                 | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Bartonsville  |                                | 22d. LOCATION (City, town, or county)<br>Bartonsville, Md (State)                      |                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Charles E. Hicks 111  |                       | ADDRESS<br>Frederick, Md   |                                 | 24a. REC'D BY REGISTRAR<br>DATE MAR 10 '59  |                                | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Trahan</i>                                  |                      |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3130 CERTIFICATE OF DEATH

Reg. Dist. No. 03098

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Myersville</b>  |                                  | b. COUNTY<br><b>Maryland</b>   |   |
| c. LENGTH OF STAY IN lb<br><b>8 years</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Myersville</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Route # 1</b>   |                                  | d. STREET ADDRESS<br><b>Route # 1.</b>   |   |
| e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>EFFIE</b>   |                                  | First<br><b>EFFIE</b>  | Middle<br><b>IRENE</b>  |
|   |                                  | Last<br><b>DELAUTER</b>  | 4. DATE<br>OF<br>DEATH<br><b>March 30</b>   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH<br><b>January 13, 1884</b>   |
| 9. AGE (In years<br>last birthday)<br><b>75 yrs.</b>  |                                  | 9. IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Emory Castle</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Manzella Brandenburg</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>[Yes, no, or unknown]<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   |
| 17. INFORMANT<br><b>Harry D. Delauter, Myersville, Md. Rt. #1</b>   |                                  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.1</b>  |                                  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>Deceased</b>   |   |
| DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c)<br><b>Arterio Sclerosis -</b>   |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |                                  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.   | Month<br>19                      | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |
| 21. I certify that I attended the deceased from <b>Mar 19, 1959</b> , to <b>Mar 30, 1959</b> , that I last saw the deceased<br>alive on <b>Mar 19, 1959</b> , and that death occurred at <b>Middleton</b> , from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><b>J. Elmer Harp M.D.</b> |                                  | ADDRESS (Street, city or town, state)<br><b>Middleton 3-31-59</b>  |   |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>April 2, 1959</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Grossnickle's</b>  |                                  | 22d. LOCATION (City, town, or county)<br><b>Nr. Myersville, Fred. Co. Md.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. E. Bittie, Myersville, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 2 '59</b>   |   |
|   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Horne</b>   |   |



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03099

3131

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |  |                                |   |   |  |                  |
|---|---------------------------|--|--------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |                           | MARYLAND   |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   | b. COUNTY<br>Frederick   |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Braddock Heights  |                           | c. LENGTH OF STAY IN 1b<br>Since 1-6-59  |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick-Rural RD#1      |   |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Vindobona Convalescent & Rest Home   |                           | d. STREET ADDRESS<br>Ceresville  |                                | e. IS RESIDENCE<br>ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   |  |                  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>First<br>EUGENE  |                           | Middle<br>DOODY, SR.   |                                | 4. DATE<br>OF<br>DEATH<br>March 11, 1959  |   | Month Day Year   |                  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>              | B. DATE OF BIRTH<br>7 Jan 1877 | 9. AGE (In years<br>last birthday)<br>82 yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Retired Laborer   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Farm  |                                | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |                  |
| 13. FATHER'S NAME<br>Eugene E. Doody  |                           | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Smelser  |                                |   |   |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None  |                                | 17. INFORMANT<br>Eugene Doody, Jr. (Same as item #2)  |   | Address  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>141.9<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)<br>DUE TO<br>(c) |                           | Cancer of tongue   |                                |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>1 yrs.  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                |   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)       |                                |   |   |  |                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>o. m.<br>p. m.   |                           | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)                                     |   | 20f. (City or town)<br>M.D. 35 E. Church St.   | (County) (State) |
| 21. I certify that I attended the deceased from 2-2, 1959, to 3-11-, 1959, that I last saw the deceased<br>alive on 3-11-, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br>Rex R. Martin, M. D.                   |                           |  |                                |   |   | ADDRESS (Street, city or town, state)<br>Frederick, Md.  |                  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>3-14-59   |                                | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Frederick Memorial Park   |   | 22d. LOCATION (City, town, or county)<br>(State)<br>Frederick, Maryland                              |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland   |                           | ADDRESS  |                                | 24a. REC'D BY REGISTRAR<br>MAR 13 '59   |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Thorne   |                  |

THE STATE OF HAWAII - DEPARTMENT OF

CERTIFICATE OF DEATH

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03100

3101

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN lb

7 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Poolesville

15 x - 2

d. STREET ADDRESS

e. IS RESIDENCE

ON A FARM?

YES  NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

March

6

1959

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years lost birthday)

yr.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Male

White

WIDOWED

DIVORCED

Oct-4-1877

81

Months

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pharmacist (Retired, owned drug store)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Charles Elgin

14. MOTHER'S MAIDEN NAME

Helen Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-30-4226

17. INFORMANT

Charles Elgin, Poolesville, Md

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

446X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

Chronic Nephritis (Nephritis)  
with Uremia

INTERVAL BETWEEN  
ONSET AND DEATH

5 years

Generalized Arteriosclerosis

10 years

(b)

(c)

19. WAS AUTOPSY PERFORMED? YES  NO

MEDICAL CERTIFICATION

Uvebral stye

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.

20d. INJURY OCCURRED  
While Not while  
of work  at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 2 February 1959, to 6 March 1959, that I last saw the deceased alive on 6 March 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

M.D.

Barnesville, Md

7 March 59

PHYSICIAN'S  
NAME (Type)

Gordon M. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

3/9/59

22c. NAME OF CEMETERY OR CREMATORIUM

Monocacy

22d. LOCATION (City, town, or county)

(State)

Beallsville, Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William B. Allen, Barnesville, Md

24a. REC'D BY REGISTRAR

MAR 1 0 '59

24b. REGISTRAR'S SIGNATURE

Arthur & Anna

STATE OF CALIFORNIA  
DEPARTMENT OF MOTOR VEHICLES  
REGISTRATION CERTIFICATE

1915

1915

1915

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper: Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03101

3126

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |  |   |   |                     |                            |   |
|--|----------------------------------|---|---|--|---|---|---------------------|----------------------------|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b>  |                                  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>  |   | c. LENGTH OF STAY IN 1b<br><b>Life</b>                       |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Maryland</b> |                     | b. COUNTY <b>Frederick</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>415 East Potomac</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brunswick</b>  |   | d. STREET ADDRESS<br><b>415 East Potomac</b>                 |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |                     |                            |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>Charles</b>  | First                            | Middle<br><b>Merrill</b>  | Last<br><b>Foster</b>                             | 4. DATE<br>OF<br>DEATH<br><b>3</b>                           | Month<br><b>11</b>                        | Day<br><b>11</b>  | Year<br><b>1959</b> |                            |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-14-1912</b>              | 9. AGE (In years<br>(on birthday)<br>yrs.<br><b>40</b>       | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b> | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  | Hours<br><b>0</b>   | Min.<br><b>0</b>           |   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Helper</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B.&amp;O. Electrician</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                     |                            |   |
| 13. FATHER'S NAME<br><b>Merrill Foster</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sadie L. Miles</b> |  |   |   |                     |                            |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Mr. Merrill Foster, Brunswick, Md.</b>   |   | Address   |                     |                            |   |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b><br/>DUE TO<br/><b>241X</b><br/>Conditions, if any, which<br/>gave rise to immediate<br/>cause (a), stating the under-<br/>lying cause last. (b) <b>asthma</b><br/>DUE TO<br/>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>                |                                  |   |   |  |   |   |                     |                            | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>.3 days</b>                                     |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br/>(If either, NOTIFY MEDICAL EXAMINER)</p> <p>20c. TIME OF INJURY Month, Day, Year<br/>Hour a. m. <b>19</b> 20d. INJURY OCCURRED<br/>p. m. <b>White</b> <b>Not white</b><br/>at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br/>20f. (City or town)<br/>(County) <b>Leviton</b> (State) <b>Md.</b></p> |                                  |   |   |  |   |   |                     |                            | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <p>21. I certify that I attended the deceased from <b>3/10</b>, 19<b>59</b>, to <b>3/11</b>, 19<b>59</b>, that I last saw the deceased<br/>alive on <b>3/10</b>, 19<b>59</b>, and that death occurred at <b>5 a.m.</b>, from the causes and on the date stated above.</p> <p>ACTUAL<br/>SIGNATURE <b>W. B. Carpenter</b> M.D. <b>Leviton</b>, <b>Md.</b> ADDRESS (Street, city or town, state) <b>Leviton</b>, <b>Md.</b> DATE SIGNED <b>3/11/59</b></p> <p>PHYSICIAN'S<br/>NAME (Type)</p>                                |                                  |   |   |  |   |   |                     |                            |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>3-13-59</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Park Heights</b>  |   | 22d. LOCATION (City, town, or county)<br><b>Brunswick, Maryland</b>   |                     |                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>G. Lee Felt</b>   |                                  | ADDRESS<br><b>Brunswick, Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 16 '59</b>            |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |                     |                            |   |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03102

3102

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |  |                                       |   |                   |                             |                               |  |
|---|----------------------------------|---|---|--|---------------------------------------|---|-------------------|-----------------------------|-------------------------------|--|
| 1. PLACE OF DEATH<br>o. COUNTY<br><b>Frederick</b>  |                                  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b> |                                       | b. COUNTY<br><b>Frederick</b>   |                   |                             |                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>50 Years</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>                 |                                       |   |                   |                             |                               |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>708 Motter Avenue</b>   |                                  |   |   | d. STREET ADDRESS<br><b>708 Motter Avenue</b>  |                                       | e. IS RESIDENCE<br>ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |                             |                               |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>GEORGE WILLIAM ALBERT</b>   |                                  | First<br><b>GEORGE</b>  | Middle<br><b>WILLIAM</b>                  | Last<br><b>ALBERT</b>  | 4. DATE<br>OF<br>DEATH<br><b>FOX</b>  | Month<br><b>March</b>   | Day<br><b>27,</b> | Year<br><b>1959</b>         |                               |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           | B. DATE OF BIRTH<br><b>August 1, 1884</b> | 9. AGE (In years<br>last birthday)<br><b>74</b>  | IF UNDER 1 YEAR<br>Months<br><b>0</b> | IF UNDER 24 HRS.<br>Days<br><b>0</b>  | Hours<br><b>0</b> | Min.<br><b>0</b>            |                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Carpenter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                   |                             |                               |  |
| 13. FATHER'S NAME<br><b>John W. Fox</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Adkins</b>   |                                       |   |                   |                             |                               |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-10-5576</b>   |   | 17. INFORMANT<br><b>Mrs. Gladys C. Fox- Same as Item #2</b>  |                                       | Address   |                   |                             |                               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c)<br><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><br>420.0<br>INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>4 yrs</b> |                                  |   |   |  |                                       |   |                   |                             |                               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |   |  |                                       |   |                   |                             |                               |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>a. m.<br>p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)  |                                       | 20f. (City or town)<br><b>Frederick</b>   |                   | (County)<br><b>Maryland</b> | (State)<br><b>Maryland</b>    |  |
| 21. I certify that I attended the deceased from <b>Dec 1956</b> to <b>March 1959</b> , that I last saw the deceased<br>alive on <b>Jan 1959</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>East Church Street</b>   |                                  |   |   |  |                                       |   |                   |                             | DATE SIGNED<br><b>3/28/59</b> |  |
| ACTUAL<br>SIGNATURE<br><i>Rex R. Martin</i>   |                                  | PHYSICIAN'S<br>NAME (Type)<br><b>Rex R. Martin, M.D.</b>  |   |  |                                       |   |                   |                             | Frederick, Maryland           |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Mar. 30, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Frederick Memorial Park</b>   |                                       | 22d. LOCATION (City, town, or county)<br><b>Frederick, Maryland</b>                                 |                   |                             | (State)<br><b>Maryland</b>    |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br><b>MAR 31 '59</b>   |                                       | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>   |                   |                             |                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

БІЗНОМІЛАН-НІДАЕНО ТРЕНІВКАНО ВІДЕО ГІДРУГА

НІДАЕНО ТРЕНІВКАНО

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3103

## CERTIFICATE OF DEATH

Reg. Dist. No.

03103

|  |                           |   |                                   |   |                                       |  |           |              |
|--|---------------------------|---|-----------------------------------|---|---------------------------------------|--|-----------|--------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                           | MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland     |                                       | b. COUNTY<br>Baltimore   |           |              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                           | c. LENGTH OF STAY IN 1b<br>Since 8/14/44  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Baltimore                     |                                       | d. STREET ADDRESS<br>4404 Glenmore Avenue  |           |              |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Maryland Odd Fellows Home   |                           |   |                                   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |                                       |  |           |              |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>MACCIE  |                           | First<br>IRENE  | Middle<br>GALLAGHER               | Last  | 4. DATE<br>OF<br>DEATH<br>March 16,   | Month<br>March   | Day<br>16 | Year<br>1959 |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                          | 8. DATE OF BIRTH<br>23 March 1872 | 9. AGE (In years<br>last birthday)<br>86  | 10. IF UNDER 1 YEAR<br>Months<br>Days | 11. IF UNDER 24 HRS.<br>Hours<br>Min.  |           |              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Auditing Dept.  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store  |                                   | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |           |              |
| 13. FATHER'S NAME<br>John T. Hamilton  |                           | 14. MOTHER'S MAIDEN NAME<br>Mary A. Hudson  |                                   |   |                                       |  |           |              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>[Yes, no, or unknown]<br>No  |                           | 16. SOCIAL SECURITY NO.<br>212-07-2771  |                                   | 17. INFORMANT<br>Maryland Odd Fellows Home Records  |                                       | Address  |           |              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>331X   |                           | Cerebral Hemorrhage   |                                   |   |                                       | INTERVAL BETWEEN<br>ONSET AND DEATH<br>4 Years   |           |              |
| DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)   |                           | Arteriosclerosis  |                                   |   |                                       | 10 Years   |           |              |
| DUE TO<br>(c)  |                           |   |                                   |   |                                       |  |           |              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |                                   |   |                                       | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)        |                                   |   |                                       |  |           |              |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not at work <input type="checkbox"/> |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |                                       |  |           |              |
| 21. I certify that I attended the deceased from _____ Jan. 1, 1959, to March 16, 1959, that I last saw the deceased<br>alive on _____ March 16, 1959, and that death occurred at 6:30 P.M., from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><i>W. M. Smith</i> |                           |   |                                   | ADDRESS (Street, city or town, state)<br>4 E. Church St.  |                                       | DATE SIGNED<br>18 Mar 59   |           |              |
| PHYSICIAN'S<br>NAME (Type)<br>William M. Smith, M. D.  |                           | Frederick, Md.  |                                   |   |                                       |  |           |              |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>3-19-59  |                                   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Druid Ridge Cemetery  |                                       | 22d. LOCATION (City, town, or county)<br>Baltimore County Maryland<br>(State)                        |           |              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland  |                           | ADDRESS   |                                   | 24a. REC'D BY REGISTRAR<br>MAR 19 '59   |                                       | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>  |           |              |

MANAGAN STATE GOVERNMENT OF MICHIGAN

CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03104

3132

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Braddock</b>   |                                  | c. LENGTH OF STAY IN lb<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Myersville</b>                      |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Vindabona Convalescent Home</b>   |                                  | d. STREET ADDRESS   |   |
| e. IS RESIDENCE<br>ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br><b>Clara</b>            | Middle<br><b>V.</b>   | Last<br><b>Gaver</b>  |
| 4. DATE<br>OF<br>DEATH  | Month<br><b>3</b>                | Day<br><b>15</b>  | Year<br><b>1959</b>   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/28/1876</b>  |
| 9. AGE (In years<br>last birthday)<br><b>82 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>02</b>  | 11. IF UNDER 24 HRS.<br>Days<br>Hours<br>Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                  | 13. FATHER'S NAME<br><b>Isiah Harp</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Sarah Gladhill</b>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                  | 17. INFORMANT<br><b>Mrs. Guy Gladhill, Myersville, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>156.1</b>  |                                  | DUE TO<br><i>Carcinoma of Liver</i>   |   |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c)   |                                  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>1 year</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>Ex hantion</i>   |                                  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>Ex hantion</i>   |   |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.   | Month<br><b>19</b>               | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input checked="" type="checkbox"/>                                  | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County)<br>(State) |
| 21. I certify that I attended the deceased from <i>Dec 31, 1958</i> , to <i>March 15, 1959</i> , that I last saw the deceased<br>alive on <i>March 14, 1959</i> , and that death occurred at <i>715 A.M.</i> from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><i>H. L. Fahrney</i> |                                  | ADDRESS (Street, city or town, state)<br><i>Middlebury, Md.</i> DATE SIGNED<br><i>March 15, 1959</i>  |   |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>burial</b>   |                                  | 22b. DATE THEREOF<br><b>3/18/1959</b>   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Lutheran Cemetery</b>  |
| 22d. LOCATION (City, town, or county)<br><b>Middletown, Md.</b>   |                                  | (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gladhill Company, Middletown, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 20 '59</b>   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Birth

Name

Date of Death

Place of Death

City

State or Province

Country

Post Office

County



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03105

## CERTIFICATE OF DEATH

Reg. Dist. No.

3133

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Emmitsburg,   |                           | c. LENGTH OF STAY IN 1b<br>3 years  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>110 East Main  |                           | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X Emmitsburg.             |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>Charles  |                           | First<br>Thomas   | Middle<br>Glacken   |
| 4. DATE<br>OF<br>DEATH<br>March 17,   | Month<br>19 59            | Day   | Year  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED<br>WIDOWED   | NEVER MARRIED<br>DIVORCED   |
| 8. B. DATE OF BIRTH<br>Feb. 15, 1889  |                           | 9. AGE (In years<br>last birthday)<br>70 yrs.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Ret. Farmer   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Fairfield, Penna.  |   |
| 11. BIRTHPLACE (State or foreign country)<br>Fairfield, Penna.  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 13. FATHER'S NAME<br>Michael Glacken  |                           | 14. MOTHER'S MAIDEN NAME<br>Sarah Wolf  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no   |                           | 16. SOCIAL SECURITY NO. 219-36-1810   |   |
| 17. INFORMANT<br>Alice R. Glacken   |                           | Address 110 E. Main<br>Emmitsburg Md.   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>191.0   |                           | INTERVAL BETWEEN<br>ONSET AND DEATH<br>7 days   |   |
| DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.   |                           | (b) Epidermoid Carcinoma of lip<br>DUE TO<br>(c) with metastasis  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                  |   |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.   | Month, Day, Year<br>19    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |
| 21. I certify that I attended the deceased from Aug 3, 1955, to March 17, 1959, that I last saw the deceased<br>alive on March 16, 1959, and that death occurred at 2:45 P.M., from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE Charles R. Williams M.D. ADDRESS (Street, city or town, state) Emmitsburg Md. DATE SIGNED 3/17/59 |                           |   |   |
| PHYSICIAN'S<br>NAME (Type)<br>Charles R. Williams   |                           | 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |   |
| 22b. DATE THEREOF<br>3/20/1959  |                           | 22c. NAME OF CEMETERY OR CREMATORIAL<br>St. Mary's Catholic   |   |
| 22d. LOCATION (City, town, or county)<br>Emmitsburg, Frederick Co., Md.   |                           | (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>C. E. Wilson  |                           | 24a. REC'D BY REGISTRAR<br>MAR 19 '59   | 24b. REGISTRAR'S SIGNATURE<br>Charles S. Horne  |
| ADDRESS<br>Emmitsburg, Md.  |                           | DATE  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

|  |     |      |                |            |             |              |
|--|-----|------|----------------|------------|-------------|--------------|
| NAME OF DECEASED   | AGE | SEX  | CAUSE OF DEATH | DEATH DATE | DEATH PLACE | DEATH NUMBER |
| JOHN SMITH   | 65  | MALE | HEART DISEASE  | 12/25/1999 | HOSPITAL    | 1234567890   |
| DEATH CERTIFICATE  |     |      |                |            |             |              |
| I, the undersigned, declare that the above information is true and correct to the best of my knowledge and belief. |     |      |                |            |             |              |
| SIGNED: JOHN SMITH   |     |      |                |            |             |              |
| PRINTED NAME: JOHN SMITH   |     |      |                |            |             |              |
| ADDRESS: 123 Main Street, Atlanta, GA 30301  |     |      |                |            |             |              |
| PHONE NUMBER: (404) 555-1234   |     |      |                |            |             |              |
| DATE ISSUED: 12/26/1999  |     |      |                |            |             |              |
| ISSUED BY: DEPARTMENT OF VITAL RECORDS   |     |      |                |            |             |              |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03106

3104

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |                  |   |   |  |          |              |
|--|--|--|------------------|---|---|--|----------|--------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |  | MARYLAND   |                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland   |   | b. COUNTY<br>Frederick   |          |              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |  | c. LENGTH OF STAY IN 1b<br>Years   |                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick   |   | d. STREET ADDRESS<br>243 Washington Street   |          |              |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>243 Washington Street   |  |  |                  | d. STREET ADDRESS<br>243 Washington Street  |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |              |
| 3. NAME OF<br>DECEASED<br>(Type or print)  |  | First<br>LILLIAN   | Middle<br>GALANA | Last<br>GOODMAN   | 4. DATE<br>OF<br>DEATH<br>March 2, 1959 | Month<br>March   | Day<br>2 | Year<br>1959 |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>White  |                  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br>26 June 1888   |          |              |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>House-wife   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |                  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |          |              |
| 13. FATHER'S NAME<br>Nathaniel Putman  |  | 14. MOTHER'S MAIDEN NAME<br>Susan Utterback  |                  |   |   | Address  |          |              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |  | 16. SOCIAL SECURITY NO.<br>None  |                  | 17. INFORMANT<br>Franklin L. Goodman (Same as item #1)  |   |  |          |              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  | INTERVAL BETWEEN<br>ONSET AND DEATH  |                  |   |   |  |          |              |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>260X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last. (b)<br>DUE TO<br>(c)  |  | ① Arteriosclerotic heart disease with<br>acute myocardial infarct. 1 day<br>② Diabetes mellitus mild over a year |                  |   |   |  |          |              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                  |   |   |  |          |              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                     |                  |   |   |  |          |              |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m. 19   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>        |                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)<br>(County) (State)  |          |              |
| 21. I certify that I attended the deceased from 10-23-1958, to 3-2-1959, that I last saw the deceased<br>alive on 3-2-1959, and that death occurred at 1:48 P.M. from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br>Rex R. Martin, M.D. |  | ADDRESS (Street, city or town, state)<br>35 E. Church St.  |                  |   |   |  |          |              |
| PHYSICIAN'S<br>NAME (Type)<br>Rex R. Martin, M.D.  |  | DATE SIGNED<br>3 March 1959  |                  |   |   |  |          |              |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 22b. DATE THEREOF<br>3-5-59  |                  | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Mount Olivet Cemetery   |   | 22d. LOCATION (City, town, or county)<br>Frederick, Maryland   |          |              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland  |  | ADDRESS<br>M. R. Etchison & Son, Frederick, Maryland   |                  | 24a. REC'D BY REGISTRAR<br>DATE MAR 4 '59   |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus  |          |              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Death

P2 5-3-76 10-12-81

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3105

## CERTIFICATE OF DEATH

03107

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                    |  |   |   |   |  |                                 |              |
|--|------------------------------------|--|---|---|---|--|---------------------------------|--------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                                    | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   | b. COUNTY  |                                 |              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                                    | c. LENGTH OF STAY IN 1b<br>Over 2 Years  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Baltimore (23)            |   | d. STREET ADDRESS<br>215 South Furrow Street   |                                 |              |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Maryland Odd Fellows Home   |                                    |  |   |   |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |              |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>WILLIAM   |                                    | First<br>WALTER  | Middle<br>HACKETT                                 | Last<br>HACKETT   | 4. DATE<br>OF<br>DEATH<br>March 10, 1959                                  | Month<br>March   | Day<br>10                       | Year<br>1959 |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White          | 7. MARRIED<br>WIDOWED <input type="checkbox"/>   | NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH<br>January 6, 1878   | 9. AGE (In years<br>less birthday)<br>81 yrs.                             | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HRS<br>Days         |              |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Unknown  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |                                 |              |
| 13. FATHER'S NAME<br>William W. Hackett  |                                    | 14. MOTHER'S MAIDEN NAME<br>Margaret J. Allen  |   |   |   |  |                                 |              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |                                    | 16. SOCIAL SECURITY NO.<br>346-12-7305   |   | 17. INFORMANT<br>Maryland Odd Fellows Home Records—Same as Item #1  |   | Address  |                                 |              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>331X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)<br>DUE TO<br>(c)                           |                                    | Cerebral Hemorrhage  |   |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>8 Days  |                                 |              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Diabetes   |                                    |  |   |   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 |              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |   |   |  |                                 |              |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.  | Month<br>19                        | Day<br>19  | Year<br>1959                                      | 20d. INJURY OCCURRED<br>While<br>of work <input type="checkbox"/> at work <input type="checkbox"/>            | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) | 20f. (City or town)<br>East Church Street  | (County)<br>Frederick, Maryland |              |
| 21. I certify that I attended the deceased from <u>March 1, 1959</u> , to <u>March 10, 1959</u> , that I last saw the deceased<br>alive on <u>March 10, 1959</u> , and that death occurred at <u>11:10A.M.</u> from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><i>W. M. Smith</i> M.D. |                                    | ADDRESS (Street, city or town, state)<br>East Church Street                                  |   | DATE SIGNED<br>3/11/1959  |   |  |                                 |              |
| PHYSICIAN'S<br>NAME (Type)<br>William M. Smith M.D.  |                                    | Frederick, Maryland  |   |   |   |  |                                 |              |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   | 22b. DATE THEREOF<br>Mar. 13, 1959 | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Cokesbury M.E. Cemetery                              |   | 22d. LOCATION (City, town, or county)<br>Dorchester County, Maryland  |   |  |                                 |              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland  |                                    | ADDRESS  |   | 24a. REC'D BY REGISTRAR<br>MAR 13 '59   | 24b. REGISTRAR'S SIGNATURE<br><i>Calvin L. Evans</i>                      |  |                                 |              |

81-25001-148-511ASH-PROVINCIAL LABORATORY OF ALBERTA

HT/30-10-1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03108

3106

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Years</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>  |  | d. STREET ADDRESS<br><b>24 West South Street</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>24 West South Street</b>  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>GROVER</b>  |  | First<br><b>CLEVELAND</b>   | Middle<br><b>HALLER</b>   |
| 4. DATE<br>OF<br>DEATH<br><b>March 20, 1959</b>   |  | 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>16 Nov 1893</b>  |   |
| 9. AGE (In years<br>last birthday)<br><b>65</b>   |  | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Retired Butcher</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Meat Packing Co.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>George W. Haller</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Nettie M. Hamilton</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>217-10-9318</b>   |   |
| 17. INFORMANT<br><b>Mrs. Maude Staub (Same as item #1)</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c) |   |
| 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>acute myocardial infarction</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |
| 21. I certify that I attended the deceased from <b>3-19-1959</b> to <b>3-20-1959</b> , that I last saw the deceased<br>alive on <b>3-20-1959</b> , and that death occurred at <b>6:50P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>35 E. Church St.</b> |  | DATE SIGNED<br><b>21 March 1959</b>   |   |
| ACTUAL<br>SIGNATURE<br><i>Rex R. Martin</i>   |  | PHYSICIAN'S<br>NAME (Type)<br><b>Rex R. Martin, M. D.</b>   |   |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3-23-59</b>   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Mount Olivet Cemetery</b>  |
| 22d. LOCATION (City, town, or county)<br><b>Frederick, Maryland</b>   |  | (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 23 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krause</b>   |

STATE OF HAWAII - GRAYHAWK

CERTIFICATE OF DEATH

DECEASED PERSON

RELATIONSHIP

AGE AT DEATH

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

NAME OF ATTENDING DOCTOR

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG239 3-9-59 et

03109

Reg. Dist. No. 1

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)                       |   |
| Frederick  |  | MARYLAND  |   | a. STATE Maryland.  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | c. LENGTH OF STAY IN 1b<br><u>9 years</u>   |   | b. COUNTY City  |   |
| Frederick  |  |   |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)   |  | d. STREET ADDRESS   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                            |   |
| Maryland Odd Fellows Home  |  | 310 S. Gilmore St.  |   | Frederick Baltimore   |   |
| Maryland Odd Fellows Home  |  |   |   | 31014   |   |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First   | Middle  | Last  | 4. DATE OF DEATH                        |
| Sarah  |  | E.  | Hannon  | March   | Month Day Year                          |
| 5. SEX   |  | 6. COLOR OR RACE  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH  | 9. AGE (In years lost birthday) 86 yrs. |
| FEMALE   |  | W.  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>         | Apr 14, 1872  | IF UNDER 1 YEAR Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)   |   |
| None   |  | None  |   | Md.   |   |
| 12. CITIZEN OF WHAT COUNTRY?   |  |   |   | USA   |   |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME  |   |   |   |
| Adam S. Bowers   |  | Elisa Boone   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.   |   | INFORMANT Address   |   |
|  |  |   |   | Walter Hannon, 1615 Frederick Rd, Catonsville   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |   |   |   |   |
| PART I. DEATH WAS CAUSED BY: <u>Arterio sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>  |  |   |   |   |   |
| IMMEDIATE CAUSE (a) <u>450.0</u>   |  |   |   |   |   |
| DUE TO <u>Partial obstruction of heart.</u> 3 days.  |  |   |   |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Particularization of heart.</u>  |  |   |   |   |   |
| DUE TO <u>(c)</u>  |  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Doy, Year<br>Hour o. m. 19 p. m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |   |
| 21. I certify that I attended the deceased from <u>March 1, 1957</u> to <u>March 1, 1957</u> that I last saw the deceased alive on <u>March 1, 1957</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. |  |   |   |   |   |
| ADDRESS (Street, city or town, state) <u>Frederick Md.</u> DATE SIGNED <u>March 1, 1957</u>  |  |   |   |   |   |
| ACTUAL SIGNATURE <u>Wm. M. Smith</u>   |  | M.D.  |   |   |   |
| PHYSICIAN'S NAME (Type) <u>Wm. M. Smith</u>  |  |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 3/4/59   |  | 22b. DATE THEREOF <u>3/4/59</u>   |   | 22c. NAME OF CEMETERY OR CREMATORIAL <u>Loudon Park Cem.</u>  |   |
|  |  |   |   | 22d. LOCATION (City, town, or county) <u>Baltimore</u>  |   |
|  |  |   |   | (State) <u>Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE   |  | ADDRESS   |   | 24a. REC'D BY REGISTRAR   |   |
| Witzke Funeral Dir. 4101 Edmondson Ave.  |  |   |   | 24b. REGISTRAR'S SIGNATURE  |   |
|  |  |   |   | DATE MAR 4 '59  |   |

BRITISH MUSEUM

Evangelical Holiness of God, now all to be

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3108

Items 1, 2 Film G229 5-16-59 et

03110

Reg. Dist. No.

|   |                              |  |                                 |
|---|------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> |                                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>                      |                              | c. LENGTH OF STAY IN 1b<br><b>20 years</b>   |                                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>"Rooming House"</b>                    |                              | e. STREET ADDRESS<br><b>19 W. All Saint Street</b>   |                                 |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>William Alfred</b>  |                              | First<br><b>William</b>  | Middle<br><b>Alfred</b>         |
| 4. DATE<br>OF<br>DEATH<br><b>March 3 1959</b>   |                              | Month<br><b>March</b>  | Day<br><b>3</b>                 |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH<br><b>1908</b> |
| 9. AGE (In years<br>last birthday)<br><b>50 yrs.</b>  |                              | 10. IF UNDER 14 YEARS<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Laborer - Waiter</b> |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                 |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co.</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                 |
| 13. FATHER'S NAME<br><b>Edward Harris</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Nettie Bowie</b>  |                                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>                                       |                              | 16. SOCIAL SECURITY NO.<br><b>2 world war</b>  |                                 |
| 17. INFORMANT<br><b>Nettie Hendrickson</b>  |                              | Address<br><b>104 W. All Saint, St</b>   |                                 |

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

**490X** Lebar Pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

5 days?

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

(b) Lower right lobe

DUE TO

(c)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

|   |                        |   |   |
|---|------------------------|---|---|
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH. |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |   |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.   | Month, Day, Year<br>19 | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) |
| 20f. (City or town)   | (County)               | (State)   |   |

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

**B.O. Thomas**

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S  
NAME (Type)

**B.O. Thomas, M.D.**

ASSISTANT MEDICAL EXAMINER

March 3, 1959

|   |                                    |   |  |
|---|------------------------------------|---|--|
| 22a. BURIAL, CREMATION<br>REMOVAL (Specify)<br><b>BURIAL</b>    | 22b. DATE THEREOF<br><b>3-6-59</b> | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>FAIRVIEW</b> | 22d. LOCATION (City, town, or county)<br><b>Frederick - Md</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>CHARLES E. HICKS III</b> |                                    | ADDRESS<br><b>Frederick, Md.</b>                        | 24a. REC'D BY REGISTRAR<br><b>MAR 10 '59</b>                   |
|   |                                    |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>          |



## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

3134

## CERTIFICATE OF DEATH

03111

Reg. Dist. No.

|  |                           |   |                                |   |  |   |                          |          |         |
|--|---------------------------|---|--------------------------------|---|--|---|--------------------------|----------|---------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                           | MARYLAND  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br>Maryland |  | b. COUNTY<br>Frederick  |                          |          |         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Burkittsville  |                           | c. LENGTH OF STAY IN 1b<br>years  |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Burkittsville             |  | d. STREET ADDRESS   |                          |          |         |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                           |   |                                |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |          |         |
| 3. NAME OF DECEASED (Type or print)<br>Clarabelle  |                           | First   | Middle                         | Lost  | 4. DATE OF DEATH<br>3                      | Month   | Day                      | Year     |         |
| 5. SEX<br>female   | 6. COLOR OR RACE<br>white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>12/13/1872 |   | 9. AGE (In years lost birthday)<br>86 yrs. | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days | Hours    | Min.    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home   |                                | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.  |                          |          |         |
| 13. FATHER'S NAME<br>Daniel Rohrback   |                           | 14. MOTHER'S MAIDEN NAME<br>Jane Weaver   |                                |   |  |   |                          |          |         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>no   |                           | 16. SOCIAL SECURITY NO.<br>none   |                                | 17. INFORMANT<br>Mrs. Leroy Cutshall, Burkittsville, Md.  |  | Address   |                          |          |         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>260x<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.  |                           | Cerebral Hemorrhage<br>DUE TO<br>(b) Diabetes<br>DUE TO<br>(c) Generalized artero-sclerosis   |                                |   |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br>15 mo<br>5 yrs.  |                          |          |         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |   |                                |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                          |          |         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                |   |  |   |                          |          |         |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>Middletown   |                          | (County) | (State) |
| 21. I certify that I attended the deceased from 1956, 19, to 3-31, 1957, that I last saw the deceased alive on May 21, 1959, and that death occurred at M, from the causes and on the date stated above.<br>ACTUAL SIGNATURE <i>J. Elmer Harp</i> M.D.<br>ADDRESS (Street, city or town, state) <i>Middle Town Md.</i> DATE SIGNED <i>4-1-59</i> |                           |   |                                |   |  |   |                          |          |         |
| PHYSICIAN'S NAME (Type)<br>Dr. J. Elmer Harp   |                           |   |                                | Middletown, Md.   |  |   |                          |          |         |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |                           | 22b. DATE THEREOF<br>4/3/1959   |                                | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Knoxville Cemetery  |  | 22d. LOCATION (City, town, or county)<br>Knoxville, Md.   |                          | (State)  |         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Gladhill Company, Middletown, Md.  |                           | ADDRESS   |                                | 24a. REC'D BY REGISTRAR<br>DATE APR 6 '59   |  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>  |                          |          |         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3135 CERTIFICATE OF DEATH

03112

Reg. Dist. No.

|  |                |   |                           |   |                                   |  |  |                                       |
|--|----------------|---|---------------------------|---|-----------------------------------|--|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick MARYLAND   |                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Md. b. COUNTY<br>Frederick |                           |   |                                   |  |  |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>rural Myersville   |                | c. LENGTH OF STAY IN 1b<br>70 years   |                           |   |                                   |  |  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>RFD #2  |                | e. IS RESIDENCE<br>ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                           |   |                                   |  |  |                                       |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>Philip  |                | First<br>Middle<br>Tennoson   | Last<br>Hoover            |   |                                   |  |  |                                       |
| 4. DATE<br>OF<br>DEATH<br>Month<br>March<br>Day<br>18,<br>Year<br>1959   | 5. SEX<br>male |   | 6. COLOR OR RACE<br>white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>June 14, 1870 | 9. AGE (In years<br>last birthday)<br>88 yrs.  | 10. IF UNDER 1 YEAR<br>Months<br>Days                    | 11. IF UNDER 24 HRS.<br>Hours<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>cabinet maker  |                | 10b. KIND OF BUSINESS OR INDUSTRY<br>wood   |                           | 11. BIRTHPLACE (State or foreign country)<br>Frederick Co., Md.   |                                   | 12. CITIZEN OF WHAT COUNTRY?   |  |                                       |
| 13. FATHER'S NAME<br>John W. Hoover  |                | 14. MOTHER'S MAIDEN NAME<br>Sarah Oswald  |                           |   |                                   |  |  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no  |                | 16. SOCIAL SECURITY NO.<br>212-18-7089  |                           | 17. INFORMANT<br>Eunice M. Wiley, Myersville Rd 2, Md.  |                                   | Address  |  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhage</u>   |                | DUE TO  |                           |   |                                   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>24 hr.  |  |                                       |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.  |                | (b) <u>Generalized Arteriosclerosis</u>   |                           |   |                                   | 5 Years  |  |                                       |
| DUE TO   |                | (c)   |                           |   |                                   |  |  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                |   |                           |   |                                   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |                           |   |                                   |  |  |                                       |
| 20c. TIME OF INJURY<br>Hour a. m. 19 p. m.   |                | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>                       |                           | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town)  | (County)   | (State)                               |
| 21. I certify that I attended the deceased from <u>6/6</u> , 19 <u>55</u> , to <u>3/18</u> , 19 <u>59</u> , that I last saw the deceased<br>alive on <u>3/18</u> , 19 <u>59</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE <u>Charles F. Krantz</u> M.D. <u>Smithsburg, Md.</u> DATE SIGNED <u>3/19/59</u> |                |   |                           |   |                                   |  |  |                                       |
| PHYSICIAN'S<br>NAME (Type) <u>Charles F. Krantz M.D.</u>   |                | 22a. BURIAL, CREMATION,<br>REMOVALS (Specify)<br>burial   |                           | 22b. DATE THEREOF<br>3-21-59  |                                   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>United Brethren Cem.   | 22d. LOCATION (City, town, or county)<br>Wolfsville, Md. | (State)                               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Scott F. Minnich &amp; Son, Smithsburg, Md.</u>   |                | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 23 '59</u>   |                           | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Krantz</u>   |                                   |  |  |                                       |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113113

3136

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                              |   |                              |  |   |   |   |
|--|------------------------------|---|------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>   |                              | MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>Maryland</i> |   | b. COUNTY<br><i>Frederick</i>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Frederick R#7</i>   |                              | c. LENGTH OF STAY IN 1b<br><i>35 days</i>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>10 Frederick</i>              |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><i>Frederick County Chronic Hosp</i>  |                              | d. STREET ADDRESS<br><i>1</i>   |                              | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   |   |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br><i>Marshall</i>     | Middle<br><i>W.</i>   | Last<br><i>Jones</i>         | 4. DATE<br>OF<br>DEATH<br><i>3 7 1959</i>  | Month<br><i>3</i>                         | Day<br><i>7</i>   | Year<br><i>1959</i>                       |
| 5. SEX<br><i>M</i>   | 6. COLOR OR RACE<br><i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>?</i> | 9. AGE (In years<br>lost birthday)<br><i>89 yrs.</i>   | 10. IF UNDER 1 YEAR<br>Months<br><i>0</i> | 11. IF UNDER 24 HRS.<br>Days<br><i>0</i>  | 12. IF UNDER 24 HRS.<br>Hours<br><i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>Day laborer</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>—</i>   |                              | 11. BIRTHPLACE (State or foreign country)<br><i>Frederick, Co.</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |   |
| 13. FATHER'S NAME<br><i>James Jones</i>  |                              | 14. MOTHER'S MAIDEN NAME<br><i>Rebecca Diggs (Deceased)</i>   |                              | Address<br><i>Ruth Crawford R.N. Sept. Frederick County Chn</i>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>(If yes, give year or dates of service)   |                              | 16. SOCIAL SECURITY NO.   |                              | 17. INFORMANT<br><i>Ruth Crawford R.N. Sept. Frederick County Chn</i>  |   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>422.1</i><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c) |   |
|  |                              |   |                              |  |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>5 yrs.</i>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><i>Fracture thru Surgical neck right femur</i> |                              |   |                              |  |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)                   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><i>Slipped and fell on floor</i>                             |                              | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <i>12 20 1958</i>   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   |
|  |                              |   |                              | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>Montgomery County, Md.</i>              |   | 20f. (City or town) (County) (State)<br><i>Fredrick Frederick Md.</i>   |   |
| 21. I certify that I attended the deceased from<br>alive on <i>May 7, 1959</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above.         |                              |   |                              | ADDRESS (Street, city or town, state)<br><i>7-11 Market St. Frederick Md.</i>  |   | DATE SIGNED<br><i>May 7, 1959</i>   |   |
| ACTUAL<br>SIGNATURE<br><i>H. F. Kline</i>  |                              | M.D.  |                              |  |   |   |   |
| PHYSICIAN'S<br>NAME (Type)<br><i>Dr. H. F. Kline</i>   |                              |   |                              |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>3-7-54</i>   |                              | 22b. DATE THEREOF<br><i>3-7-54</i>  |                              | 22c. NAME OF CEMETERY, OR CREMATORIAL BOARD<br><i>Anatomical Board</i>   |   | 22d. LOCATION (City, town, or county)<br><i>Baltimore Md.</i>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>R. C. Shirley</i>   |                              | ADDRESS<br><i>Frederick Md.</i>   |                              | 24a. REC'D BY REGISTRAR<br><i>Mar 24 '59</i>   |   | 24b. REGISTRAR'S SIGNATURE<br><i>John C. H. H.</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3109

## CERTIFICATE OF DEATH

Reg. Dist. No.

03114

|   |  |   |   |   |   |  |                               |  |           |
|---|--|---|---|---|---|--|-------------------------------|--|-----------|
| 1   |  | X   |   | 3109  |   | CERTIFICATE OF DEATH   |                               |  |           |
| TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4   |  |   |   |   |   |  |                               |  |           |
| may be retained by the hospital or attending physician.   |  |   |   |   |   |  |                               |  |           |
| TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.   |  | 69  |   |   |   |  |                               |  |           |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   | b. COUNTY<br>Frederick   |                               |  |           |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick   |  | c. LENGTH OF STAY IN lb<br>Years  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick                 |   |  |                               |  |           |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Frederick Memorial Hospital  |  |   |   | d. STREET ADDRESS<br>308 Sherman Avenue   |   |  |                               | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First<br>TANEY  | Middle<br>BLAND   | Lost<br>KAUFMAN   | 4. DATE<br>OF<br>DEATH<br>March<br>22, 1959 | Month<br>March   | Day<br>22                     | Year<br>1959   |           |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>White   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH<br>1 Sept 1898   | 9. AGE (In years<br>last birthday)<br>60    | IF UNDER 1 YEAR<br>Months<br>0                                       | IF UNDER 24 HRS.<br>Days<br>0 | Hours<br>0   | Min.<br>0 |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Steward   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Railroad   |   | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |                               |  |           |
| 13. FATHER'S NAME<br>William C. Kaufman   |  |   |   | 14. MOTHER'S MAIDEN NAME<br>Anna Kehne  |   |  |                               |  |           |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |  | 16. SOCIAL SECURITY NO.<br>705-12-4825  |   | 17. INFORMANT<br>Mrs. Rose M. Kaufman (Same as item #2)   |   | Address  |                               |  |           |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>420.0<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first.<br>(b)<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Acute Coronary Thrombosis<br>Arteriosclerotic Heart Disease<br>INTERVAL BETWEEN<br>ONSET AND DEATH<br>1 day |  |   |   |   |   |  |                               |  |           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |  |                               |  |           |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. — 19<br>p. m. —   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)<br>Frederick, Md.                                |                               | (County)   | (State)   |
| 21. I certify that I attended the deceased from <u>March 21, 1959</u> to <u>March 22, 1959</u> , that I last saw the deceased alive on <u>March 22, 1959</u> , and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.<br>ACTUAL SIGNATURE <u>A. A. Pearre</u> ADDRESS (Street, city or town, state) <u>4 E. Church St.</u> DATE SIGNED <u>23 March 1959</u>  |  |   |   |   |   |  |                               |  |           |
| PHYSICIAN'S NAME (Type)<br>A. A. Pearre, M. D.  |  | Frederick, Md.  |   |   |   |  |                               |  |           |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 22b. DATE THEREOF<br>3-24-59  |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>St. John's Cemetery   |   | 22d. LOCATION (City, town, or county)<br>Frederick, Maryland (State) |                               |  |           |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland   |  | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br>DATE MAR 24 '59  |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus                        |                               |  |           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3137

## CERTIFICATE OF DEATH

03115

Reg. Dist. No.

|   |                              |   |  |   |  |
|---|------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>  |                              |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Frederick</b> |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hopehill Route 2</b>   |                              |   | c. LENGTH OF STAY IN lb<br><b>45 yrs.</b>  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Hopehill Rt. 2</b>  |                              |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br><b>John</b>         | Middle<br><b>Oliver</b>   | Last<br><b>Lee</b>   | 4. DATE<br>OF<br>DEATH<br><b>March 8 1959</b>   | Month<br>Day<br>Year                                   |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 12-1883</b>  | 9. AGE (In years<br>last birthday)<br><b>75</b><br>yrs.   | 10. IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Stone Quarry</b>   |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>   |                              |   | 12. CITIZEN OF WHAT COUNTRY?   |   |  |
| 13. FATHER'S NAME<br><b>John R. Lee</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>Bessie Hill</b>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>214-14-6747</b>   |  | INFORMANT<br><b>Luratta Lee-- Hopehill Rt. 2-Fred. Co. Md.</b>  | Address  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>177X</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Metastatic carcinoma of prostate</b><br>INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>year</b> |                              |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |  |
| 21. I certify that I attended the deceased from _____, 19 <b>56</b> , to _____, 19 <b>58</b> , that I last saw the deceased<br>alive on _____, 19 <b>59</b> , and that death occurred at _____, M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>Frederick, Maryland</b>   |                              |   |  |   |  |
| ACTUAL<br>SIGNATURE<br><b>James B. Thomas</b><br>M.D.   |                              |   |  |   |  |
| DATE SIGNED<br><b>3/9/59</b>  |                              |   |  |   |  |
| 22a. BURIAL, Cremation,<br>REMOVAL (Specify)<br><b>Burial</b>   |                              | 22b. DATE THEREOF<br><b>Mar. 11-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>Hopehill</b>   |  |
| 22d. LOCATION (City, town, or county)<br><b>Frederick Co. Md.</b>   |                              |   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Hicks III Frederick, Md.</b>  |                              |   |  |   |  |
| ADDRESS   |                              |   |  |   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 13 '59</b>   |                              |   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>  |                              |   |  |   |  |



03116

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3110 CERTIFICATE OF DEATH

Reg. Dist. No. M

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Frederick</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Since 5/20/38</b> // <b>Frederick</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Home for the Aged</b>  |                                  | d. STREET ADDRESS<br><b>625 North Market Street</b> e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>XX</b> |  |
| 3. NAME OF DECEASED<br>(Type or print)   | First <b>CLARA</b>               | Middle <b>VIRGINIA</b>  | Last <b>LIEB</b>   |
| 4. DATE OF DEATH   | Month <b>March</b>               | Day <b>24</b>   | Year <b>1959</b>   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>5 Nov 1865</b>   |
| 9. AGE (In years last birthday) <b>93</b> yrs.   |                                  | 10. IF UNDER 1 YEAR <input type="checkbox"/>  | 11. IF UNDER 24 HRS. <input type="checkbox"/>  |
|  |                                  | Months <b>0</b>   | Days <b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-work</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |                                  |   |  |
| 13. FATHER'S NAME <b>John Diller</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Ellen Cramer</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO. <b>None</b>   | 17. INFORMANT <b>Home for the Aged Records (Same as item #1)</b>   |
|  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b><br>DUE TO<br>(c) <b>Arterio-Sclerosis</b> |                                  | <b>2 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b></b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>228 N. Market St., Frederick, Md.</b> |
| 20f. (City or town) <b>Frederick</b> (County) <b>Md.</b> (State) <b>Md.</b>  |                                  |   |  |
| 21. I certify that I attended the deceased from <b>22 Mar 1957</b> to <b>24 Mar 1957</b> that I last saw the deceased alive on <b>23 Mar 1959</b> , and that death occurred at <b>5:50A M.</b> from the causes and on the date stated above.         |                                  |   |  |
| ACTUAL SIGNATURE <b>Charles H. Conley</b>  |                                  | ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b> DATE SIGNED <b>24 March 1959</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr. M. D.</b>  |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>3-27-59</b> | 22c. NAME OF CEMETERY OR CEMINATORY <b>Mount Hope Cemetery</b>  | 22d. LOCATION (City, town, or county) <b>Woodsboro, Maryland</b> (State) <b>Md.</b>                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>  |                                  | 24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |
|  |                                  | DATE <b>MAR 26 '59</b>  |  |

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03117

3138

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b> <b>rural</b>   |  | c. LENGTH OF STAY IN b<br><b>9 mos.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Own Home</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Thurmont</b> <b>rural</b>  |   |
| d. STREET ADDRESS  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br><b>Vernon</b>   | Middle<br><b>Lee</b>  | Last<br><b>Martin</b>   |
| 4. DATE<br>OF<br>DEATH   | Month<br><b>March</b>  | Day<br><b>16</b>  | Year<br><b>1959</b>   |
| S. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 4, 1958</b>                                       |
| 9. AGE (In years<br>lost birthday)<br>yrs.<br><b>9</b>   | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>None</b> | 11. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   | 12. BIRTHPLACE (State or foreign country)<br><b>Gettysburg Hospital</b>       |
| 13. CITIZEN OF WHAT COUNTRY?<br><b>u.s.a.</b>  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Louise Burkett</b>   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   | 16. SOCIAL SECURITY NO.<br><b>None</b>   | INFORMANT<br><b>Lee H. Martin</b>   | Address<br><b>Thurmont, Md. RR 2</b>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Gastro enteritis</b><br>DUE TO<br>571.0<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c) |  |   |   |
| INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>3 days</b>   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |   |   |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.<br>19  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> at work <input type="checkbox"/>           | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   | 20f. (City or town)<br>(County)<br>(State)                                    |
| 21. I certify that I attended the deceased from <b>June 4, 1958</b> , to <b>March 16, 1959</b> , that I last saw the deceased<br>alive on <b>March 15, 1959</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.   |  |   |   |
| ACTUAL<br>SIGNATURE<br><i>Charles R. Williams, M.D.</i>  | ADDRESS (Street, city or town, state)<br><b>Emmitsburg, Md.</b> DATE SIGNED<br><b>3/16/59</b>                |   |   |
| PHYSICIAN'S<br>NAME (Type)<br><b>Charles R. Williams</b>   |  |   |   |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>3-18-59</b>  | 22c. NAME OF CEMETERY OR CEMATORIAL<br><b>Blue Ridge Cemetery</b>   | 22d. LOCATION (City, town, or county)<br>(State)<br><b>Thurmont, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Raymond E. Creager</b>  | ADDRESS<br><b>Thurmont, Maryland</b>   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 19 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Caroline S. Kline</b>                        |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PTACO TO ADH152

Notes and

bullets

Leave tomorrow

800

Leave Friday

11 notes

all day

all day

all day

Leave early

all day

all day

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03118

3111

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                           |   |                                 |   |                                     |
|--|---------------------------|---|---------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Caroline                               |                                 |   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick Since 2/29/48  |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Denton 05x-2  |                                 |   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Maryland Odd Fellows Home   |                           | d. STREET ADDRESS   |                                 |   |                                     |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>First CAPTOLIA  |                           | 4. DATE<br>OF<br>DEATH<br>Last METO<br>Month March<br>Day 5, 1959<br>Year   |                                 |   |                                     |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>16 Dec 1878 |   |                                     |
| 9. AGE (In years<br>last birthday)<br>80 yrs.  |                           | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>House-work   |                                 | 11. BIRTHPLACE (State or foreign country)<br>Maryland   | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
| 13. FATHER'S NAME<br>Henry Baker   |                           | 14. MOTHER'S MAIDEN NAME<br>Nancy Brodis  |                                 | Address   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None   |                                 | 17. INFORMANT<br>Odd Fellows Home Records (Same as item #1)   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>331x<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first.<br>(b)<br>DUE TO<br>(c)   |                           | Cerebral Hemorrhage<br>Arteriosclerosis   |                                 | INTERVAL BETWEEN<br>ONSET AND DEATH<br>7 weeks<br>5 yrs.  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           |   |                                 | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                 |   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19<br>p.m.   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |                                     |
| 21. I certify that I attended the deceased from Feb 26, 1959, to March 5, 1959, that I last saw the deceased<br>alive on March 5, 1959, and that death occurred at 5 P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>ACTUAL SIGNATURE William M. Smith, M.D. 4 E. Church St.<br>DATE SIGNED 6 March 1959 |                           |   |                                 |   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>3-7-59   |                                 | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Hill Crest Cemetery   |                                     |
| 22d. LOCATION (City, town, or county)<br>Federalsburg, Maryland  |                           | (State)   |                                 |   |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland  |                           | ADDRESS   |                                 | 24a. REC'D BY REGISTRAR<br>DATE MAR 9 '59   |                                     |
| 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Krause   |                           |   |                                 |   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

STATE OF MARYLAND—DEPARTMENT OF STATE—QUALITY

CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03119

3112

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br><b>Laura</b>  | Middle<br><b>V</b>  | 4. DATE<br>OF<br>DEATH<br><b>March 29 1959</b>                            |
| S. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>                                     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/8/1881</b>                                       |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>              |
| 13. FATHER'S NAME<br><b>Amos O'neal</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte Younkins</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  | 17. INFORMANT<br>Address<br><b>Donald Moss, Burkittsville, Md.</b>        |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0</b><br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first.<br><b>Anterior-lateral Heart disease</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)<br><br>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Bronchopneumonia, bilateral.</b> |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.  | Month<br>19  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>of work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.) |
| 20f. (City or town)  | (County)   | (State)   |   |
| 21. I certify that I attended the deceased from <b>3/26</b> , 1959, to <b>3/29</b> , 1959, that I last saw the deceased<br>alive on <b>3/29</b> , 1959, and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>4 E. Church St</b>  |  |   |   |
| ACTUAL<br>SIGNATURE<br><i>Henry V. Chase</i>   | DATE SIGNED<br><b>3/29/59</b>                                    |   |   |
| PHYSICIAN'S<br>NAME (Type)<br><b>Henry V. Chase</b>  | 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>burial</b>    |   |   |
| 22b. DATE THEREOF<br><b>4/1/1959</b>   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Lutheran Cemetery</b> | 22d. LOCATION (City, town, or county)<br><b>Middletown, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Gladhill Company, Middletown, Md.</b>   | ADDRESS  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>APR 2 '59</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Poore</b>                      |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03120

3139

## CERTIFICATE OF DEATH

Reg. Dist. No.

1  
ath. Page 4  
eral director,  
be filed with

24 hours  
the attending physician  
Pages 1 and  
and in any event within 72 hours after death'

TO HOSPITAL OR  
may be retained  
the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital or attending physician, attach for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

|   |                              |   |   |
|---|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>FREDERICK</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>UNION BRIDGE RURAL</b>   |                              | b. COUNTY<br><b>FREDERICK</b>   |   |
| c. LENGTH OF STAY IN 1b<br><b>7 MONTHS</b>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>UNION BRIDGE</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>00  |                              | d. STREET ADDRESS<br><b>1</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>JULIA REMINA NELSON</b>   |                              | First   | Middle  |
|   |                              | Last  |   |
| 4. DATE OF DEATH<br>Month<br><b>MARCH</b>   |                              | Day<br><b>29</b>  | Year<br><b>1959</b>   |
| S. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 22-1866</b>  |
| 9. AGE (In years lost birthday)<br><b>92 yrs.</b>   |                              | 10. IF UNDER 1 YEAR<br>Months<br><b>0</b>   | 11. IF UNDER 24 HRS.<br>Days<br><b>0</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>WISCONSIN</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |                              |   |   |
| 13. FATHER'S NAME<br><b>SWEN HANSON</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  | 17. INFORMANT<br><b>CLARENCE R NELSON</b>   |
|   |                              | Address<br><b>MD UNION BRIDGE</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b>   |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |   |
| DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>Generalized Arteriosclerosis</b>   |                              |   |   |
| (b)<br>DUE TO<br><b>Generalized Arteriosclerosis</b>  |                              | Years<br><b>Years</b>   |   |
| (c)   |                              |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m.<br>p. m.<br><b>19</b>   |                              | 20d. INJURY OCCURRED<br>White Not white<br>at work <input type="checkbox"/> of work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)<br><b>M.D. 118 S. Main St., Union Bridge, Md.</b> |
| 21. I certify that I attended the deceased from <b>Nov 30, 1958</b> , to <b>March 29, 1959</b> , that I last saw the deceased alive on <b>March 28, 1959</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above.<br>ACTUAL SIGNATURE<br><b>Joseph H. Caricofe</b> |                              | ADDRESS (Street, city or town, state)<br><b>March 29, 59</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>JOSEPH H. CARICOFE</b>  |                              | DATE SIGNED   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                              | 22b. DATE THEREOF<br><b>4/2/59</b>  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>GREENWOOD</b>  |
| 22d. LOCATION (City, town, or county)<br><b>BEMIDJI</b>   |                              | (State)<br><b>MINN.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>DD Hartzler &amp; Sons Union Bridge, Md</b>  |                              | 24a. REC'D BY REGISTRAR<br>DATE<br><b>APR 1 '59</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Traas</b>  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

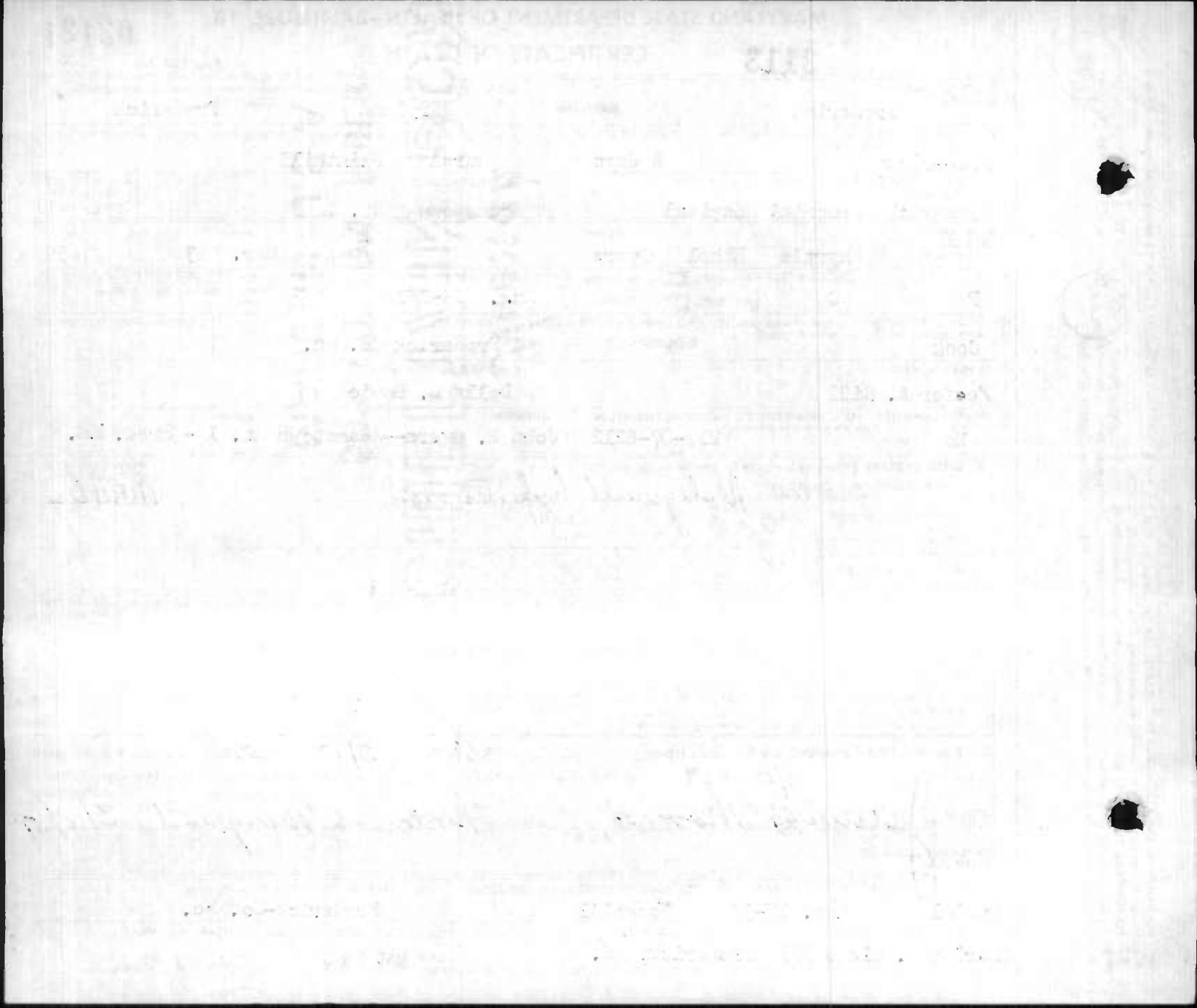
03121

3113

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>Frederick</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |   | c. LENGTH OF STAY IN 1b<br><b>6 days</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Frederick Memorial Hospital</b>  |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br><b>Myrtle</b>  | Middle<br><b>Ethel</b>  | Last<br><b>Overs</b>   |
| 4. DATE<br>OF<br>DEATH   | Month<br><b>Mar.</b>  | Day<br><b>13</b>  | Year<br><b>1959</b>  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>C</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 25-1918</b>                                      |
| 9. AGE (In years<br>last birthday)<br><b>40</b><br>yrs.  | 10. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Cook</b>    | 11. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>  | 12. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>        |
| 13. FATHER'S NAME<br><b>Feefer A. Hill</b>   | 14. MOTHER'S MAIDEN NAME<br><b>Della D. Bowie</b>   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  |
| 16. SOCIAL SECURITY NO.<br><b>217-07-8212</b>  | 17. INFORMANT<br><b>John E. Overs—Adamstown Rt. 1 - Fred. Md.</b>   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Maligant hypertension</i><br>DUE TO<br><b>445X</b><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first.<br>(b)<br>DUE TO<br>(c) |   |   |  |
| INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>Myrtle</b>   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)                    |   |  |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.<br>19  | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   | 20f. (City or town)<br>(County) (State)                                      |
| 21. I certify that I attended the deceased from _____, 1959, to _____, 1959, that I last saw the deceased<br>alive on _____, 1959, and that death occurred at _____, M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>Frederick, Maryland</b>                                 |   |   |  |
| ACTUAL<br>SIGNATURE<br><i>James B. Thomas</i>  | PHYSICIAN'S<br>NAME (Type)<br><b>James B. Thomas, M.D.</b>  | DATE SIGNED<br><b>3/16/59</b>   |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Mar. 17-59</b>  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Hopehill</b>   | 22d. LOCATION (City, town, or county)<br>(State)<br><b>Frederick Co. Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Hicks III Frederick, Md.</b>   |   | ADDRESS   | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 23 '59</b>                            |
|  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>                        |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03122

Reg. Dist. No.

|   |                                   |   |  |                                 |   |                  |            |  |
|---|-----------------------------------|---|--|---------------------------------|---|------------------|------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY  | Frederick                         |   | MARYLAND   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | Maryland         |            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  | Mt. Liberty, Md.                  |   | 32 yrs   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      | Mt. Liberty, Md. |            |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                   |   |  |                                 | d. STREET ADDRESS   |                  |            |  |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   |   |  |                                 |   |                  |            |  |
| 3. NAME OF DECEASED (Type or print)   | First                             | Middle  | Last   | 4. DATE OF DEATH                | Month   | Day              | Year       |  |
| Lillian   |                                   | May   | Owens  | March                           | 30  | 1959             |            |  |
| 5. SEX  | 6. COLOR OR RACE                  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>        | 8. DATE OF BIRTH   | 9. AGE (in years from birthday) | IF UNDER 1 YEAR   | IF UNDER 24 HRS. |            |  |
| F   | W                                 | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                | Nov. 12, 1902  | 58 yrs.                         | Months  | Days             | Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)   | 12. CITIZEN OF WHAT COUNTRY?   |                                 |   |                  |            |  |
| Domestic  | RESIDENCE                         | Maryland  | U.S.A.   |                                 |   |                  |            |  |
| 13. FATHER'S NAME   | 14. MOTHER'S MAIDEN NAME          |   |  |                                 |   |                  |            |  |
| HARRY W. OWENS  | GERTRUDE B. SMITH                 |   |  |                                 |   |                  |            |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  | 16. SOCIAL SECURITY NO.           | 17. INFORMANT   | Address  |                                 |   |                  |            |  |
| 21  | NONE                              |   | Harry L. Owens Union Bridge Rd.  |                                 |   |                  |            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |                                   |   |  |                                 |   |                  |            |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |                                   |   |  |                                 |   |                  |            |  |
| 420.1 DUE TO Congestive heart failure 15 hrs.   |                                   |   |  |                                 |   |                  |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial Infarct 2 hrs.   |                                   |   |  |                                 |   |                  |            |  |
| (c)   |                                   |   |  |                                 |   |                  |            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                   |   |  |                                 |   |                  |            |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                   |   |  |                                 |   |                  |            |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |                                   |   |  |                                 |   |                  |            |  |
| 20c. TIME OF INJURY   | Month, Day, Year                  | 20d. INJURY OCCURRED  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)             | (County)  | (State)          |            |  |
| Hour<br>a. m.<br>p. m.  | 19                                | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |                                 |   |                  |            |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                   |   |  |                                 |   |                  |            |  |
| ACTUAL SIGNATURE  | B. O. Thomas                      |   |  |                                 | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                  | DATE SIGNED      |            |  |
| EXAMINER'S NAME (Type)  | B. O. Thomas                      |   |  |                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                   |                  |            |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF                 | 22c. NAME OF CEMETERY OR CREMATORIAL  | 22d. LOCATION (City, town, or county)                                  | (State)                         |   |                  |            |  |
| BURIAL  | 4-1-59                            | STILL POND CEMET  | STILL POND   | MD.                             |   |                  |            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                           | 24a. REC'D BY REGISTRAR   | 24b. REGISTRAR'S SIGNATURE   |                                 |   |                  |            |  |
| Victor N. Kennedy   | STILL POND, MD                    | DATE APR 1 '59  | Arthur S. Thomas   |                                 |   |                  |            |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03123

3114

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                           |  |   |  |  |  |               |
|---|---------------------------|--|---|--|--|--|---------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |                           | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland          |  | b. COUNTY<br>Frederick   |               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick   |                           | c. LENGTH OF STAY IN 1b<br>Life  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>// Frederick                       |  | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>18 West South Street |               |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>18 West South Street   |                           | d. STREET ADDRESS<br>18 West South Street  |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |  |               |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>HARRY  |                           | First<br>GARFIELD  | Middle<br>PHEBUS                                  | Lost   | 4. DATE<br>OF<br>DEATH<br>Month<br>March | Day<br>17  | Year<br>1959  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                | B. DATE OF BIRTH<br>11 March 1878                 | 9. AGE (In years<br>lost birthday)<br>81 yrs.  | IF UNDER 1 YEAR<br>Months                | IF UNDER 24 HRS.<br>Days   | Hours<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Brick Mason  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Self-employed   |   | 11. BIRTHPLACE (State or foreign country)<br>Frederick, Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |               |
| 13. FATHER'S NAME<br>Benjamin F. Phebus   |                           |  | 14. MOTHER'S MAIDEN NAME<br>Annie E. Hergesheimer |  |  |  |               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>None  |   | 17. INFORMANT<br>Mrs. Bessie I. Phebus (Same as item #1)   |  | Address  |               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>420.0<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)<br>DUE TO<br>(c)             |                           | Gastric Thrombosis   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>1 day   |  |  |               |
| Gastric & Atherosclerotic Heart Disease   |                           | Generalized Arteriosclerosis   |   |  |  |  |               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Prostatic Hypertrophy (Benign)  |                           |  |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |  |               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |   |  |  |  |               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. — 19 p. m. —   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>March 16, 1959, to March 17, 1959, at 2 P.M. |  |  |               |
| 20f. (City or town)<br>—  |                           | (County)<br>—  |   | (State)<br>—   |  |  |               |
| 21. I certify that I attended the deceased from <u>March 16, 1959</u> , to <u>March 17, 1959</u> , that I last saw the deceased<br>alive on <u>March 17, 1959</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br>A. A. Pearre |                           | ADDRESS (Street, city or town, state)<br>4 E. Church St.   |   | DATE SIGNED<br>18 March 1959   |  |  |               |
| PHYSICIAN'S<br>NAME (Type)<br>A. A. Pearre, M. D.   |                           | Frederick, Md.   |   |  |  |  |               |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>3-20-59   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Mount Olivet Cemetery  |  | 22d. LOCATION (City, town, or county)<br>(State)<br>Frederick, Maryland                                  |               |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland   |                           | ADDRESS  |   | 24a. REC'D BY REGISTRAR<br>DATE MAR 19 '59   |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Krause   |               |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03124

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |   |                          |                     |
|---|---|---|--|---|--------------------------|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Maryland</i>  |  |   |                          |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Frederick</i>  |   | c. LENGTH OF STAY IN 1b<br><i>2 days</i>  |  |   |                          |                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><i>Frederick Memorial Hosp</i>   |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |                          |                     |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><i>Michael</i>   |   | First<br><i>Michael</i>   | Middle<br><i>Wayne</i>   |   |                          |                     |
| 4. DATE<br>OF<br>DEATH<br><i>March 29 1959</i>  | Month<br><i>March</i>   | Day<br><i>29</i>  | Year<br><i>1959</i>  |   |                          |                     |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>28 March 59</i>   |   |                          |                     |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>—</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>—</i>   | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>                       |   |                          |                     |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>Cash</i>   |   | 13. FATHER'S NAME<br><i>Charles M. Rice</i>   | 14. MOTHER'S MAIDEN NAME<br><i>Catherine Specht</i>                                |   |                          |                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>—</i>   | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><i>—</i> | 17. INFORMANT<br><i>Father</i>  | Address<br><i>RFD 2 Middletown Md.</i>   |   |                          |                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>776X</i>   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>Prematurity</i>   |  |   |                          |                     |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br><i>—</i>  |   |   |  |   |                          |                     |
| DUE TO<br><i>—</i>  |   |   |  |   |                          |                     |
| DUE TO<br><i>—</i>  |   |   |  |   |                          |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |                          |                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><i>—</i>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>—</i>  |  |   |                          |                     |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.<br><i>19</i>   | Month, Day<br><i>March 28</i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br><i>—</i>                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>—</i> | 20f. (City or town)<br><i>—</i>                       | (County)<br><i>—</i>     | (State)<br><i>—</i> |
| 21. I certify that I attended the deceased from <i>28 March, 1959</i> , to <i>29 March, 1959</i> , that I last saw the deceased alive on <i>29 March, 1959</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.<br>ACTUAL SIGNATURE<br><i>A. M. Powell</i> |   | ADDRESS (Street, city or town, state)<br><i>220 N. Market St. Frederick, Md.</i>  |  | DATE SIGNED<br><i>30 March 1959</i>                   |                          |                     |
| PHYSICIAN'S NAME (Type)<br><i>Dr. A. M. Powell</i>  |   |   |  |   |                          |                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i>  | 22b. DATE THEREOF<br><i>3/31/1959</i>   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>Methodist Cemetery</i>   | 22d. LOCATION (City, town, or county)<br><i>Jefferson, Md.</i>                     | (State)<br><i>—</i>                                   |                          |                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Gladhill Co., Middletown, Md.</i>  |   | ADDRESS<br><i>—</i>   | 24a. REC'D BY REGISTRAR<br><i>—</i>  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Thorne</i> | DATE<br><i>APR 2 '59</i> |                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and on any event within 72 hours of death.

## CERTIFICATE OF DEATH

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |    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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 | 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 | 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 | 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 | 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 | 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 | 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3116

## CERTIFICATE OF DEATH

Reg. Dist. No. 13125

|   |  |  |  |  |   |   |  |  |
|---|--|--|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>FREDERICK</b>  |  | MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b> |   | b. COUNTY<br><b>FREDERICK</b>   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FREDERICK</b>  |  | c. LENGTH OF STAY IN 1b<br><b>5 DAYS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FREDERICK</b>                 |   | d. STREET ADDRESS<br><b>ROUTE 1</b>   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>FREDERICK CO. CHRONIC HOSP. NEAR LIBERTY TOWN</b>  |  |  |  | d. STREET ADDRESS  |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>W. SCOTT RIPPEON</b>  |  | First  | Middle   | Last   | 4. DATE OF DEATH<br><b>MARCH 8 1959</b> | Month   | Day  | Year   |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG 25-1881</b>   |   | 9. AGE (In years lost birthday) yrs.<br><b>77</b>   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SELF EMP.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |
| 13. FATHER'S NAME<br><b>BRADLEY T. RIPPEON</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARTHA FRITZ</b>  |  |  |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>219-20-0380</b>  |  | 17. INFORMANT<br><b>PEARL C. RIPPEON</b>   |   | Address<br><b>FREDERICK RIMD.</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>331X</b>   |  | DUE TO<br><i>Cerebral Hemorrhage</i>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>   |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)  |  | <i>Small Pox</i>   |  |  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town)<br><b>LIBERTY TOWN</b>  |  | (County) <b>MONTGOMERY</b> (State) <b>MARYLAND</b> |
| 21. I certify that I attended the deceased from <b>May 1959</b> to <b>Aug 20 1959</b> that I last saw the deceased alive on <b>Aug 20 1959</b> and that death occurred at <b>LIBERTY TOWN</b> from the causes and on the date stated above. |  |  |  | ADDRESS (Street, city or town, state)<br><b>Montgomery Md. 20709</b>   |   | DATE SIGNED<br><b>Aug 20 1959</b>   |  |  |
| ACTUAL SIGNATURE<br><b>J. H. MESSLER</b>  |  |  |  |  |   |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>J. H. MESSLER M.D.</b>  |  |  |  |  |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 22b. DATE THEREOF<br><b>3/11/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIAL<br><b>FAIRMOUNT CEM</b>   |   | 22d. LOCATION (City, town, or county)<br><b>LIBERTY TOWN</b>                                      |  | (State) <b>MARYLAND</b>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>D. D. Bentzons, Liberty Town Md.</b>   |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br><b>Arthur S. Kraus</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |
|   |  |  |  | DATE<br><b>MAR 12 '59</b>  |   |   |  |  |

BY DIRECTIVE OF THE STATE GOALYRAN

STABO TO STABO

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 7 FilmG241 4-7-59 et  
**CERTIFICATE OF DEATH**

03126

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Maryland</i> |   | Reg. Dist. No.  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Mount Airy</i>  |  | c. LENGTH OF STAY IN 1b<br><i>83</i>   |   | b. COUNTY<br><i>Frederick</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>—  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Mount Airy</i>                |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br><i>Orry Francis Runkles</i>   |  | First  | Middle  | Last  | 4. DATE OF DEATH<br><i>March 31 1959</i>  |
| 5. SEX<br><i>Male</i>  |  | 6. COLOR OR RACE<br><i>White</i>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><i>July 14, 1875</i>  | Month<br><i>83</i>  |
| 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Farmor</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Farm</i>   |   | 9. AGE (In years last birthday)<br>yrs.<br><i>83</i>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |   |
| 13. FATHER'S NAME<br><i>William Henry Runkles</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Emily Van Sant</i>  |   | Address   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>  |  | 16. SOCIAL SECURITY NO.<br><i>218-24-9366</i>  |   | 17. INFORMANT<br><i>Mrs. Norman Watkins (Daughter)</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Arteriosclerotic Heart Disease</i>  |  | DUE TO<br><i>4200</i>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 years</i>  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)   |  | DUE TO   |   |   |   |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |   |   |   |
| 20c. TIME OF INJURY<br>Hour<br>a. m.<br>p. m.<br><i>19</i>   |  | Month<br><i>March</i>  | Day<br><i>30</i>  | Year<br><i>1959</i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br>(County)<br>(State)   |   |   |   |
| 21. I certify that I attended the deceased from <i>1955</i> , to <i>March</i> , 1959, that I last saw the deceased alive on <i>March 30, 1959</i> , and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)<br><i>30. Main Street</i>  |   | DATE SIGNED<br><i>3/31/59</i>   |   |
| ACTUAL SIGNATURE<br><i>W.B. Culwell</i>  |  | M.D.   |   |   |   |
| PHYSICIAN'S NAME (Type)<br><i>W.B. Culwell</i>   |  |  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 22b. DATE THEREOF<br><i>4/3/59</i>   | 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>Prospect Meth.</i>   | 22d. LOCATION (City, town, or county)<br>(State)<br><i>Nr. Mt. Airy, Md.</i>                      |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Oliver L. Molesmith</i>   |  | ADDRESS<br><i>Damascus, Md.</i>  | 24a. REC'D BY REGISTRAR<br>DATE<br><i>APR 3 '59</i>   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Thorne</i>   |   |

## CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03127

3117

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                              |  |                                     |   |                                       |   |  |  |
|--|------------------------------|--|-------------------------------------|---|---------------------------------------|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |                              | MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Md.</b> |                                       | b. COUNTY<br><b>Frederick</b>   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frederick</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>Hrs.</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Frederick</b>         |                                       | d. STREET ADDRESS<br><b>140 W. All Saints Street</b>  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Frederick Memorial Hospital</b>   |                              |  |                                     |   |                                       | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>John Nathan Sewell Jr.</b>  |                              | First  | Middle                              | Last  | 4. DATE OF DEATH<br><b>Mar 3 1959</b> | Month   | Day  | Year                                       |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>C</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>3-9-1910</b> | 9. AGE (In years last birthday)<br><b>48 yrs.</b>   | 10. IF UNDER 1 YEAR<br>Months         | 11. IF UNDER 24 HRS.<br>Days  | 12. IF UNDER 24 HRS.<br>Hours  | 13. IF UNDER 24 HRS.<br>Min.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Gen. Utilities</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Frederick City Md.</b>  |                                       | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| 13. FATHER'S NAME<br><b>John N. Sewell Sr.</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Mary Anna Walker</b>  |                                     |   |                                       |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>212-14-6503</b>  |                                     | INFORMANT<br><b>Alice F. Sewell - 140 W. All Saints St. Fred.</b>   |                                       | Address<br><b>Md.</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><b>Acute myocardial infarction</b><br><b>420.1</b><br><b>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a)</b><br><b>DUE TO</b><br><b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b><br><b>(b)</b><br><b>DUE TO</b><br><b>(c)</b><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> |                              |  |                                     |   |                                       |   |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |                              |  |                                     |   |                                       |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     | 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.  |                                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | 20f. (City or town)<br>(County)<br>(State) |
| 19   |                              |  |                                     |   |                                       |   |  |  |
| 21. I certify that I attended the deceased from <b>3-3-</b> , 19 <b>59</b> , to <b>3-3-</b> , 19 <b>59</b> that I last saw the deceased alive on <b>3-3-</b> , 19 <b>59</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.<br><b>P.M.</b> ADDRESS (Street, city or town, state)<br><b>Church Street ; Frederick, Md.</b> DATE SIGNED<br><b>Arthur S. Trahan</b>  |                              |  |                                     |   |                                       |   |  |  |
| ACTUAL SIGNATURE<br><b>Rex. Martin</b>   |                              | M.D.   |                                     |   |                                       |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Rex. Martin</b>  |                              | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> 22b. DATE THEREOF<br><b>3-7-59</b> 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Fairview</b> 22d. LOCATION (City, town, or county)<br><b>Frederick, Md.</b> (State) |                                     |   |                                       |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles E. Hicks III Frederick, Md.</b>   |                              | ADDRESS  |                                     | 24a. REC'D BY REGISTRAR<br>DATE<br><b>MAR 10 '59</b>  |                                       | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Trahan</b>   |  |  |

Feb 1

Introducing a new

type of

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03128

3118

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>MARYLAND</i>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Frederick</i>  |   | c. LENGTH OF STAY IN 1b<br><i>15 hrs</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><i>Fred. Memorial Hospital</i>   |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rural, Ladiesburg</i>   |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><i>RAYMOND Bay P Smith</i>   |   | d. STREET ADDRESS<br><i>1</i>  |   |
| 4. DATE<br>OF<br>DEATH<br><i>March 28 1959</i>  | Month<br>Month<br><i>March</i>            | Day<br>Days<br><i>28</i>   | Year<br>Hours<br>Min.<br><i>1959</i>      |
| 5. SEX<br><i>M</i>  | 6. COLOR OR RACE<br><i>W</i>              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><i>June 11, 1897</i>  |
| 9. AGE (In years<br>last birthday)<br><i>61 yrs.</i>  | 10. IF UNDER 1 YEAR<br>Months<br><i>0</i> | 11. IF UNDER 24 HRS.<br>Days<br><i>0</i>   | 12. IF UNDER 24 HRS.<br>Hours<br><i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>Farmer</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>own farm</i>   |   |
| 10c. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |   |
| 13. FATHER'S NAME<br><i>Charles Smith</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Cecilia Smith</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>Yes</i>   |   | 16. SOCIAL SECURITY NO. <i>219-36-4636</i>   |   |
| 17. INFORMANT<br><i>Mrs. Lillian Smith, Detour, R. I., Md.</i>  |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>Diffuse generalized peritonitis</i>  |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>12 hrs</i>   |   |
| DUE TO<br><i>154X</i><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br><i>Intestinal obstruction</i>   |   | 12 hrs   |   |
| (b)<br>DUE TO<br><i>Carcinoma of rectosigmoid</i>   |   | undetermined.  |   |
| (c)   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>a. m.<br>p. m.<br><i>19</i>  |   | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   |   | 20f. (City or town)<br>(County) (State)  |   |
| 21. I certify that I attended the deceased from <i>27 Mar 1959</i> to <i>28 Mar 1959</i> that I last saw the deceased<br>alive on <i>28 Mar 1959</i> , and that death occurred at <i>9:45 AM</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><i>35 E. Church St</i> |   |  |   |
| ACTUAL<br>SIGNATURE<br><i>Melvin E. Lea M.D.</i>  |   | DATE SIGNED<br><i>30 Mar 59</i>  |   |
| PHYSICIAN'S<br>NAME (Type)<br><i>Melvin E. Lea M.D.</i>   |   |  |   |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |   | 22b. DATE THEREOF<br><i>Mar 31, 1959</i>   |   |
| 22c. NAME OF CEMETERY OR CREMATORIAL<br><i>U. B. Cemetery</i>   |   | 22d. LOCATION (City, town, or county)<br><i>Thurmont</i>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>G.C. Barton</i>  |   | 24a. ADDRESS<br><i>Walkersville, Md.</i>   |   |
| 24b. REC'D BY REGISTRAR<br>DATE <i>APR 1 '59</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Tamm</i>  |   |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 18 Film 240 3-20-59 ams  
 3119

03129

Reg. Dist. No.

CERTIFICATE OF DEATH

|  |                           |   |                                 |   |   |  |           |                                   |                              |
|--|---------------------------|---|---------------------------------|---|---|--|-----------|-----------------------------------|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                           | MARYLAND  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   | b. COUNTY<br>Carroll   |           |                                   |                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                           | c. LENGTH OF STAY IN lb<br>Since 6/2/50   |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Mount Airy                |   | d. STREET ADDRESS<br>06 X-2  |           |                                   |                              |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Maryland Odd Fellows Home   |                           |   |                                 | d. STREET ADDRESS   |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |                                   |                              |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>FANNIE  |                           | First<br>E.   | Middle<br>.                     | Last<br>SNIDER  | 4. DATE<br>OF<br>DEATH<br>March 12, 1959      | Month<br>March   | Day<br>12 | Year<br>1959                      |                              |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>23 Jan 1880 |   | 9. AGE (In years<br>last birthday)<br>79 yrs. | IF UNDER 1 YEAR<br>Months<br>Days  |           | IF UNDER 24 HRS.<br>Hours<br>Min. |                              |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>House-work   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>At Home  |                                 | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |           |                                   |                              |
| 13. FATHER'S NAME<br>Singleton G. Gartrell   |                           | 14. MOTHER'S MAIDEN NAME<br>Martha A. Spurrier  |                                 |   |   |  |           |                                   |                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |                           | 16. SOCIAL SECURITY NO.<br>None   |                                 | 17. INFORMANT<br>Odd Fellows Home Records (Same as item #1)   |   | Address  |           |                                   |                              |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>141.9  |                           | DUE TO<br>Nephathelia of the Tongue   |                                 | Epithelioma   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>8 months  |           |                                   |                              |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)   |                           | DUE TO<br>Chronic Myocarditis   |                                 |   |   | 3 years  |           |                                   |                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           |   |                                 |   |   |  |           |                                   |                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                 |   |   |  |           |                                   |                              |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour<br>a. m.<br>p. m.  |                           | 20d. INJURY OCCURRED<br>White<br>at work <input type="checkbox"/> Not white<br>at work <input type="checkbox"/>   |                                 | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)                                     |   | 20f. (City or town)<br>Frederick   |           | (County)<br>Frederick             | (State)<br>Maryland          |
| 21. I certify that I attended the deceased from <u>July 12</u> , 1958, to <u>Mar. 12</u> , 1959, that I last saw the deceased<br>alive on <u>July 12</u> , 1958, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>4 E. Church St., M.D. |                           |   |                                 |   |   |  |           |                                   | DATE SIGNED<br>14 March 1959 |
| ACTUAL<br>SIGNATURE<br>William M. Smith  |                           | Frederick, Md.  |                                 |   |   |  |           |                                   |                              |
| PHYSICIAN'S<br>NAME (Type)   |                           |   |                                 |   |   |  |           |                                   |                              |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>3-16-59  |                                 | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Marvin Chapel Cemetery  |   | 22d. LOCATION (City, town, or county)<br>(State)<br>Frederick County Maryland                        |           |                                   |                              |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland  |                           | ADDRESS   |                                 | 24a. REC'D BY REGISTRAR<br>DATE MAR 17 '59  |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus  |           |                                   |                              |

MISSOURI STATE DEPARTMENT OF HEALTH - VOLUME 19

CERTIFICATE OF DEATH

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |    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    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |  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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 8010 | 8011 | 8012 | 8013 | 8014 | 8015 | 8016 | 8017 | 8018 | 8019 | 8020 | 8021 | 8022 | 8023 | 8024 | 8025 | 8026 | 8027 | 8028 | 8029 | 8030 | 8031 | 8032 | 8033 | 8034 | 8035 | 8036 | 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80420 | 80421 | 80422 | 80423 | 80424 | 80425 | 80426 | 80427 | 80428 | 80429 | 80430 | 80431 | 80432 | 80433 | 80434 | 80435 | 80436 | 80437 | 80438 | 80439 | 80440 | 80441 | 80442 | 80443 | 80444 | 80445 | 80446 | 80447 | 80448 | 80449 | 80450 | 80451 | 80452 | 80453 | 80454 | 80455 | 80456 | 80457 | 80458 | 80459 | 80460 | 80461 | 80462 | 80463 | 80464 | 80465 | 80466 | 80467 | 80468 | 80469 | 80470 | 80471 | 80472 | 80473 | 80474 | 80475 | 80476 | 80477 | 80478 | 80479 | 80480 | 80481 | 80482 | 80483 | 80484 | 80485 | 80486 | 80487 | 80488 | 80489 | 80490 | 80491 | 80492 | 80493 | 80494 | 80495 | 80496 | 80497 | 80498 | 80499 | 80500 | 80501 | 80502 | 80503 | 80504 | 80505 | 80506 | 80507 | 80508 | 80509 | 80510 | 80511 | 80512 | 80513 | 80514 | 80515 | 80516 | 80517 | 80518 | 80519 | 80520 | 80521 | 80522 | 80523 | 80524 | 80525 | 80526 | 80527 | 80528 | 80529 | 80530 | 80531 | 80532 | 80533 | 80534 | 80535 | 80536 | 80537 | 80538 | 80539 | 80540 | 80541 | 80542 | 80543 | 80544 | 80545 | 80546 | 80547 | 80548 | 80549 | 80550 | 80551 | 80552 | 80553 | 80554 | 80555 | 80556 | 80557 | 80558 | 80559 | 80560 | 80561 | 80562 | 80563 | 80564 | 80565 | 80566 | 80567 | 80568 | 80569 | 80570 | 80571 | 80572 | 80573 | 80574 | 80575 | 80576 | 80577 | 80578 | 80579 | 80580 | 80581 | 80582 | 80583 | 80584 | 80585 | 80586 | 80587 | 80588 | 80589 | 80590 | 80591 | 80592 | 80593 | 80594 | 80595 | 80596 | 80597 | 80598 | 80599 | 80600 | 8060 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|----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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3142

## CERTIFICATE OF DEATH

Reg. Dist. No.

03130

|  |  |   |   |  |  |  |                          |         |
|--|--|---|---|--|--|--|--------------------------|---------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Frederick</b>   |  | MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Montgomery</b>                                   |                          |         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Mt. Airy</b>   |  | c. LENGTH OF STAY IN 1b<br><b>4 months</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Damascus</b>                  |  | d. STREET ADDRESS<br><b>15 x-2<br/>9812 Hawkins Creamery Rd.</b> |                          |         |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Day Nursing Home</b>   |  |   |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |  |                          |         |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><b>Annie</b>  |  | First   | Middle  | Lost   | 4. DATE<br>OF<br>DEATH<br><b>March 29</b>            | Month  | Day                      | Year    |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                | B. DATE OF BIRTH<br><b>June 26, 1891</b>   | 9. AGE (In years<br>lost birthday)<br><b>67</b> yrs. | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HRS.<br>Days | Hours   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Laytonsville, Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                       |                          |         |
| 13. FATHER'S NAME<br><b>Thomas Allnutt</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Waters Miller</b>   |   |  |  |  |                          |         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-24-4730</b>   |   | 17. INFORMANT<br><b>Samuel Martin Speck, Damascus, Md.</b>   |  | Address  |                          |         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>170x</b>  |  | DUE TO<br><b>Heart Failure.</b>   |   | INTERVAL BETWEEN<br>ONSET AND DEATH  |  |  |                          |         |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.  |  | (b) <b>Generalized Metastasis of Cinci-</b>   |   |  |  |  |                          |         |
| DUE TO<br><b>lung in bones, lungs &amp; Brain</b>  |  | (c)   |   |  |  |  |                          |         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Primary Carcinoma in Right Breast.</b>  |  |   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |  |                          |         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>1957</b> |   |  |  |  |                          |         |
| 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.   |  | Month, Day, Year<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Salem</b>                               | 20f. (City or town)<br><b>Brookville, Md.</b>        | (County)   | (State)                  |         |
| 21. I certify that I attended the deceased from <b>1957</b> , to <b>3/29</b> , 1957, that I last saw the deceased alive on <b>March 30</b> , 1957, and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. |  |   |   | ADDRESS (Street, city or town, state)<br><b>108 N. Frederick Ave.</b>  |  | DATE SIGNED  |                          |         |
| ACTUAL<br>SIGNATURE<br><b>Lucius L. Leal</b>   |  |   |   |  |  |  |                          |         |
| PHYSICIAN'S<br>NAME (Type)<br><b>Lucius L. Leal M.D.</b>   |  |   |   |  |  |  |                          |         |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>April 1, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Salem</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Brookville, Md.</b>  |                          | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Oliver L. Moleworth</b>   |  | ADDRESS<br><b>Damascus, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>APR 1 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>             |                          |         |



## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

3143

## CERTIFICATE OF DEATH

Reg. Dist. No.

03131

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Hansonville   |   | b. COUNTY<br>Frederick  |   |
| c. LENGTH OF STAY IN 1b<br>18 months  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Hansonville         |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Route 3  |   | d. STREET ADDRESS<br>Route 3  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br>Annie  | Middle<br>P. A.   | Last<br>Stang   |
| 4. DATE OF<br>DEATH<br>March 31   | Month<br>19 59  | Day   | Year  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White   | 7. MARRIED<br>WIDOWED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH<br>8-22-1883   |
| 9. AGE (In years<br>lost birthday)<br>75 yrs.   | 10. IF UNDER 1 YEAR<br>Months   | 11. IF UNDER 24 HRS.<br>Days  | 12. IF UNDER 24 HRS.<br>Hours   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Housewife   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   | 11. BIRTHPLACE (State or foreign country)<br>Maryland   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                  |
| 13. FATHER'S NAME<br>Philip Washington Summers  | 14. MOTHER'S MAIDEN NAME<br>Margaret Zimmerman  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT<br>Mrs. Raymond S. Snoots-Sr. Hansonville, Md.  | Address<br>Route 3  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>350X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b)<br>DUE TO<br>(c) |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>6 mo<br>4 yrs  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>A drained generalized scleroderma   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)               |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. p. m.<br>19  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br>(County)<br>(State)                              |
| 21. I certify that I attended the deceased from _____, 1950, to _____, 1959, that I last saw the deceased<br>alive on _____, 1959, and that death occurred at 9:35 P.M., from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><i>J. A. Brice</i> M.D.                |   |   |   |
| PHYSICIAN'S<br>NAME (Type)<br>Dr. A. Talbot Brice   |   | ADDRESS<br>Jefferson- Maryland  |   |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  | 22b. DATE THEREOF<br>April 3-1959   | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Mt. Olivet Cemetery   | 22d. LOCATION (City, town, or county)<br>(State)<br>Frederick- Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Robert E. Dailey</i>   |   | 24a. REC'D BY REGISTRAR<br>DATE APR 6 '59   |   |
|   |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Thorne  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 20-21 Film 240 4-3-59 ams  
3120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 103132

|  |  |   |   |   |   |  |  |  |                                 |                            |                       |
|--|--|---|---|---|---|--|--|--|---------------------------------|----------------------------|-----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Frederick</i>  |   | c. LENGTH OF STAY IN 1b<br><i>15 hrs.</i>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><i>Maryland</i> |  | b. COUNTY<br><i>Baltimore</i>  |                                 |                            |                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Frederick Memorial Hospital</i>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Baltimore</i>  |   | d. STREET ADDRESS<br><i>1016 W. Cross St.</i>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |                                 |                            |                       |
| 3. NAME OF DECEASED (Type or print)<br><i>Howard</i>   |  | First<br><i>H</i>   | Middle<br><i>W</i>  | Last<br><i>STOLTE</i>   | 4. DATE OF DEATH<br><i>March 15 1959</i>          | Month<br><i>March</i>  | Day<br><i>15</i>                         | Year<br><i>1959</i>  |                                 |                            |                       |
| 5. SEX<br><i>M</i>   |  | 6. COLOR OR RACE<br><i>W</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><i>May 31 1935</i>  | 9. AGE (in years last birthday)<br><i>23 yrs.</i> | 10. IF UNDER 1 YEAR<br>Months<br><i>0</i>  | 11. IF UNDER 24 HRS.<br>Days<br><i>0</i> | 12. IF UNDER 24 HRS.<br>Hours<br><i>0</i>  |                                 |                            |                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Sheet Metal worker (unemployed)</i>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore</i>                                     |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  |                                 |                            |                       |
| 13. FATHER'S NAME<br><i>Bernard J. Stolte</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Mary T. Yeager</i>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><i>No</i>                   |   | 16. SOCIAL SECURITY NO.<br><i>Address</i>  |  |  |                                 |                            |                       |
| 17. INFORMANT<br><i>Bernard J. Stolte 1016 West Cross Street</i>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><i>Crushed Cervical Spinal Cord</i> |   | 19. INTERVAL BETWEEN ONSET AND DEATH<br><i>15 hrs</i>   |   |  |  |  |                                 |                            |                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><i>823X</i>  |  | DUE TO<br><i>(b) Fractured Cervical Vertebrae</i>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |                                 |                            |                       |
| DUE TO<br><i>(c)</i>   |  |   |   |   |   |  |  |  |                                 |                            |                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  |  |                                 |                            |                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br><i>Car ran into embankment</i>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>Car ran into embankment</i>                                      |   | 20c. TIME OF INJURY<br>Hour<br><i>5 p.m.</i>  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><i>Morgan Station Road</i> | 20f. (City or town)<br><i>-</i> | (County)<br><i>Carroll</i> | (State)<br><i>Md.</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |   |   |   |   |  |  |  |                                 |                            |                       |
| ACTUAL SIGNATURE<br><i>B. P. Thomas</i>  |  | EXAMINER'S NAME (Type)<br><i>B. P. Thomas</i>   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED  |  |  |                                 |                            |                       |
|  |  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |  |  |                                 |                            |                       |
|  |  |   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |  |  |  |                                 |                            |                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 22b. DATE THEREOF<br><i>3-24-59</i>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Cedar Hill Cemetery</i>                                |   | 22d. LOCATION (City, town, or county)<br><i>5829 Ritchie Highway</i>   |  | (State)<br><i>Zone 25</i>  |                                 |                            |                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Wm. C. Cook, Inc., 1217 St. Paul Street, Zone 2</i>   |  | ADDRESS   |   | 24a. REC'D BY REGISTRAR<br><i>MAR 23 '59</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Koenig</i>  |  |  |                                 |                            |                       |
|  |  |   |   | DATE  |   |  |  |  |                                 |                            |                       |



81  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03133

Reg. Dist. No.

3121

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   | MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland<br>b. COUNTY Frederick  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>69<br>Frederick   | c. LENGTH OF STAY IN 1b<br>hour  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X Thurmont Rural.  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Frederick Memorial Hospital   | e. STREET ADDRESS  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle<br>Lucy Belva Toms   | 4. DATE OF DEATH<br>Lost Month Doy Year<br>3 30 1959   |  |   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 17th, 1898 | 9. AGE (In years, last birthday)<br>61 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  | 11. BIRTHPLACE (State or foreign country)<br>Md  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |
| 13. FATHER'S NAME<br>Charles Cline  | 14. MOTHER'S MAIDEN NAME<br>Sally Shupp  | Address<br>Lantz P.O., MD  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   | 16. SOCIAL SECURITY NO.<br>220-05-0852   | 17. INFORMANT<br>Howard Toms   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>2 hours  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br>816X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause lost.<br>(b)<br>DUE TO<br>(c)<br>Crushed chest<br>Lacerated liver  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br>20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>Tractor trailer drifted across road--ran into car             |  |  |   |
| 20c. TIME OF INJURY<br>Hour<br>11:30 p.m.   | Month, Day, Year<br>3 29 1959  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>Route # 15<br>20f. (City or town)<br>Catoctin Furn. Fred. Md.<br>(County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL<br>SIGNATURE<br>B. O. Thomas, M. D.  | DATE SIGNED<br>March 30, 1959  |  |   |
| EXAMINER'S<br>NAME (Type)<br>B. O. Thomas, M. D.  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |
| 22a. BURIAL, CREMATION, ETC. (Specify)<br>BURIAL  | 22b. DATE THEREOF<br>Apr. 2.1959   | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Mt. Bethel Methodist Cem. Garfield. Fredk. CO. MD  | 22d. LOCATION (City, town, or county)<br>(State)  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Raymond E. Greager  | ADDRESS<br>Thurmont. MD  | 24a. REC'D BY REGISTRAR<br>DATE APR 2 '59  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Thomas  |
| Thurmont. MD  |  |  |   |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03134

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

3122

|   |  |   |   |  |   |   |                              |                 |
|---|--|---|---|--|---|---|------------------------------|-----------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 3122<br>Frederick   |   | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) |                              |                 |
| b. CITY OR TOWN (If outside corporate limits, write RURAL)  |  | Frederick<br>Catoctin Furnace   |   | c. LENGTH OF STAY IN 1b<br>hr.   |   | a. STATE Maryland<br>b. COUNTY Frederick  |                              |                 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | Frederick Memorial Hospital   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |   | Thurmont Rural  |                              |                 |
| 3. NAME OF<br>DECEASED<br>(Type or print)   |  | First<br>Raymond  | Middle<br>Harrison  | Lost<br>Toms   | 4. DATE<br>OF<br>DEATH                    | Month<br>3  | Doy<br>30                    | Year<br>1959    |
| 5. SEX  |  | 6. COLOR OR RACE  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH   | 9. AGE (in years<br>last birthday)        | 10. IF UNDER 1 YEAR<br>Months   | 11. IF UNDER 24 HRS.<br>Days |                 |
| Male  |  | White   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | April 15, 1893   | 65 yrs.                                   | Hours   | Min.                         |                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) |   |                              |                 |
| Laborer   |  |   | Contractors   |  | MD  |   |                              |                 |
| 13. FATHER'S NAME   |  |   |   | 14. MOTHER'S MAIDEN NAME   |   |   |                              |                 |
| Alfred Toms   |  |   |   | Cora Maken   |   |   |                              |                 |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   | Address   |                              |                 |
| Yes <input type="checkbox"/> W.W.I  |  | 213-18-0852   |   | Howard Toms  |   | Lantz, P.O. Md  |                              |                 |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |   |   |  |   |   |                              |                 |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)   |  |   |   |  |   |   |                              |                 |
| 816X<br>DUE TO<br>Crushed chest   |  |   |   |  |   |   |                              |                 |
| Conditions, if any, which<br>gave rise to immediate cause<br>(o), stating the underlying<br>cause last. (b)<br>DUE TO<br>Lacerated aorta  |  |   |   |  |   |   |                              |                 |
| C (c)   |  |   |   |  |   |   |                              |                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |  |   |   |  |   |   |                              |                 |
| 20. WAS AUTOPSY<br>PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |   |                              |                 |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |                              |                 |
| 20c. TIME OF INJURY<br>Hour: 11:30 p.m.<br>Month, Day, Year: 3-29-59  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |   | 20f. (City or town)<br>Catoctin Fur. Fred.  |                              | (County)<br>Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | DATE SIGNED<br>March 30, 1959   |   |  |   |   |                              |                 |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |   |  |   |   |                              |                 |
| 22a. BURIAL, CREMATION,<br>REMAINS<br>BURIAL  |  | 22b. DATE THEREOF<br>Apr. 2, 1959   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Mt. Bethel Methodist Com. Garfield       |   | 22d. LOCATION (City, town, or county)<br>Fredk Co., MD                                |                              |                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Raymond E. Greager  |  | ADDRESS<br>Thurmont, MD   |   | 24a. REC'D BY REGISTRAR<br>APR 2 '59   |   | 24b. REGISTRAR'S SIGNATURE<br>Ciribus S. Thomas                                       |                              |                 |
| Raymond E. Greager  |  |   |   |  |   |   |                              |                 |

MASSACHUSETTS DEPARTMENT OF HEALTH - CALIFORNIA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
CALIFORNIA

30

## 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03135

3144

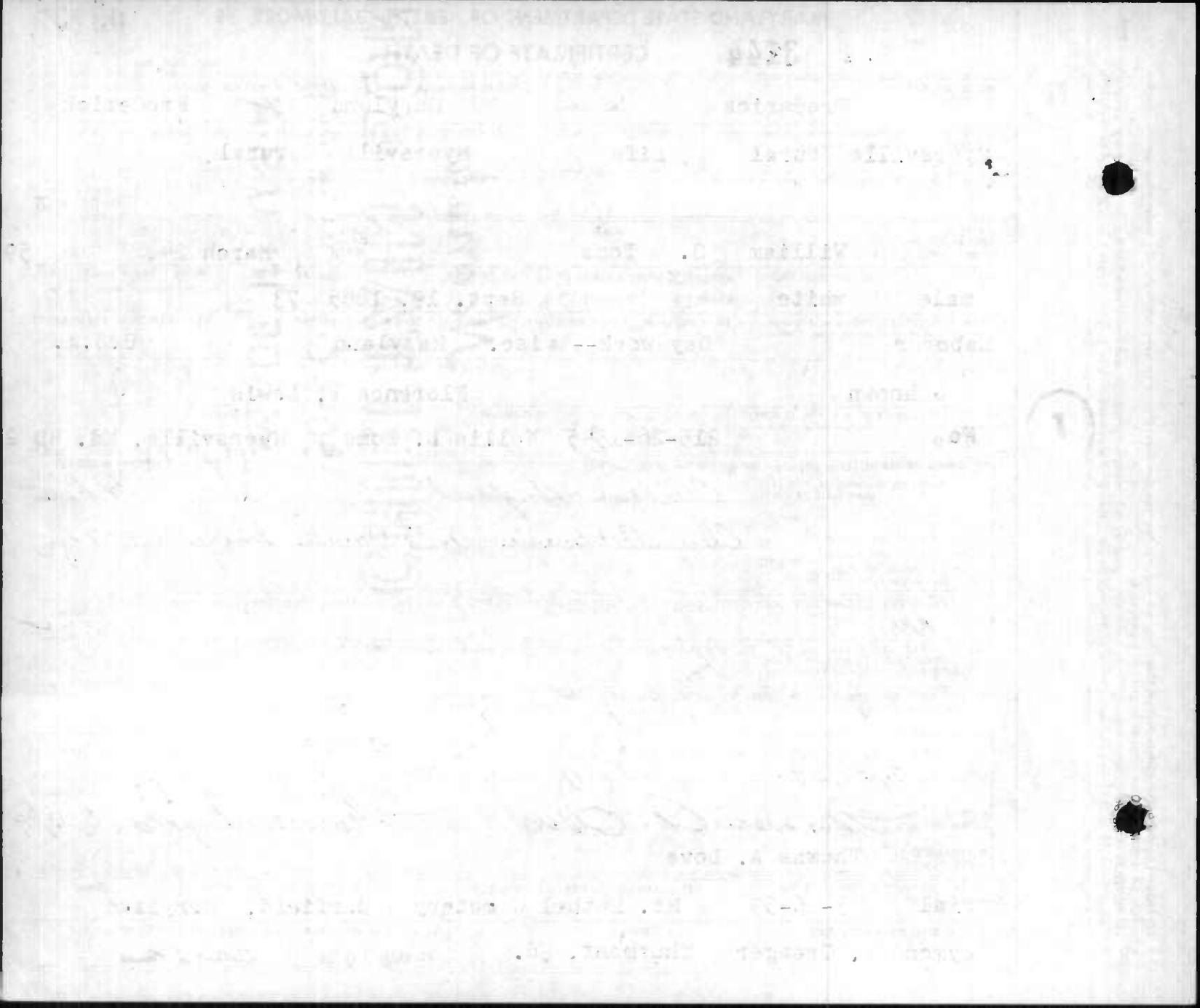
## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | Frederick MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | c. LENGTH OF STAY IN 1b  |   | a. STATE Maryland b. COUNTY Frederick  |  |
| Myersville rural  |  | Life   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  | d. STREET ADDRESS  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)  |  | First  | Middle  | Last   | 4. DATE OF DEATH<br>Month Day Year         |
| William O. Toms   |  |  |   |  | March 24, 19 59                            |
| 5. SEX  |  | 6. COLOR OR RACE   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH   | 9. AGE (In years last birthday)<br>73 yrs. |
| male  |  | white  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    | Sept. 19, 1885   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)  |  |
| Laborer   |  | Day work-- misc.   |   | Maryland   |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME   |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Unknown   |  | Florence V. Lewis  |   | U.S.A.   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, unknown)  |  | 16. SOCIAL SECURITY NO.  |   | INFORMANT Address  |  |
| No  |  | 215-26-1545  |   | Nellie L. Toms Myersville, Md. RD 2  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |  |   |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Anemia</u> DUE TO <u>422.1</u>  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Art. Sclerotic Arcl-Vascular disease</u> DUE TO <u>5-7 yrs</u> (c) _____  |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>No</u> 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>X</u> 19 p. m. _____  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X</u> 20f. (City or town) <u>X</u> (County) <u>X</u> (State) _____ |  |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>3-23-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/20/59</u> , 19 <u>59</u> , and that death occurred at <u>1:10</u> M, from the causes and on the date stated above. |  |  |   |  |  |
| ACTUAL SIGNATURE<br><i>Thomas A. Love</i>   |  | ADDRESS (Street, city or town, state)<br><i>Thurmont, Md.</i>  |   | DATE SIGNED<br><i>3/25/59</i>  |  |
| PHYSICIAN'S NAME (Type)<br><i>Thomas A. Love</i>  |  | 22a. BURIAL, CREMATION,<br>BUTTER <input checked="" type="checkbox"/> (Specify) 22b. DATE THEREOF<br>3-26-59 22c. NAME OF CEMETERY OR CREMATORIAL<br>Mt. Bethel Cemetery 22d. LOCATION (City, town, or county)<br>Garfield, Maryland (State) |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Raymond E. Creager</i>   |  | ADDRESS<br><i>Thurmont, Md.</i>  |   | 24a. REC'D BY REGISTRAR<br>DATE <i>MAR 30 '59</i> 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Thomas</i>                                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3123

## CERTIFICATE OF DEATH

Reg. Dist. No.

03136

|   |                           |  |                                  |   |   |   |                             |
|---|---------------------------|--|----------------------------------|---|---|---|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |                           | MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Maryland |   | b. COUNTY<br>Frederick  |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick   |                           | c. LENGTH OF STAY IN lb<br>Life  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick                 |   |   |                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Frederick Memorial Hospital  |                           | d. STREET ADDRESS<br>117 East 8th Street   |                                  | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |   |   |                             |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>GEORGE   |                           | First<br>ELDRED  | Middle<br>VANFOSSEN              | Lost<br>3 March 1874  | 4. DATE<br>OF<br>DEATH<br>Month<br>March<br>Day<br>17,<br>Year<br>19 59 | Month<br>March  | Day<br>17,<br>Year<br>19 59 |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                   | B. DATE OF BIRTH<br>3 March 1874 | 9. AGE (In years<br>lost birthday)<br>85 yrs.   | IF UNDER 1 YEAR<br>Months<br>Days                                       | IF UNDER 24 HRS.<br>Hours<br>Min.   |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Master Mechanic (Retired)  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Brush Company   |                                  | 11. BIRTHPLACE (State or foreign country)<br>Frederick, Maryland  |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                             |
| 13. FATHER'S NAME<br>W. Scott VanFossen   |                           | 14. MOTHER'S MAIDEN NAME<br>Harriett Dutrow  |                                  |   |   |   |                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes or no, or unknown)<br>No   |                           | 16. SOCIAL SECURITY NO.<br>309-01-9340   |                                  | 17. INFORMANT<br>Mrs. Vida V. Lahne (Same as item #2)   |   | Address   |                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>420.0<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost.<br>(b) |                           | Arteriosclerotic heart disease   |                                  |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>2-3 years  |                             |
| DUE TO<br>(c)   |                           |  |                                  |   |   |   |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |                                  |   |   |   |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) |                                  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.  |   | 20d. INJURY OCCURRED<br>White<br>Not white<br>of work <input type="checkbox"/> of work <input type="checkbox"/> |                             |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town)<br>(County) (State)  |                                  |   |   |   |                             |
| 21. I certify that I attended the deceased from 3-1, 1954, to 3-17, 1959, that I last saw the deceased<br>alive on 3-17, 1959, and that death occurred at 9:55 A.M. from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><i>Rex R. Martin</i> M.D.   |                           | ADDRESS (Street, city or town, state)<br>35 E. Church St.                                    |                                  | DATE SIGNED<br>18 March 1959  |   |   |                             |
| PHYSICIAN'S<br>NAME (Type)<br>Rex R. Martin, M. D.  |                           | Frederick, Md.   |                                  |   |   |   |                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 22b. DATE THEREOF<br>3-20-59   |                                  | 22c. NAME OF CEMETERY OR CEMETORY<br>Mount Olivet Cemetery  |   | 22d. LOCATION (City, town, or county)<br>Frederick, Maryland<br>(State)   |                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland   |                           | ADDRESS  |                                  | 24a. REC'D BY REGISTRAR<br>DATE MAR 20 '59  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Thane</i>  |                             |

18 DEPARTMENT OF HEALTH-ENVIRONMENT

CERTIFICATE OF DEATH

RECEIVED

SEARCHED

INDEXED

FILED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3145

## CERTIFICATE OF DEATH

Reg. Dist. No.

03137

|  |   |   |   |                        |                       |
|--|---|---|---|------------------------|-----------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Frederick</i>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><i>Maryland</i>  |   |                        |                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Mt. Airy</i>  | c. LENGTH OF STAY IN 1b<br><i>11 yrs</i>  | b. COUNTY<br><i>Frederick</i>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Mount Airy</i> |                        |                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><i>500 Hill street</i>  | d. STREET ADDRESS<br><i>Same</i>  |   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                        |                       |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><i>William</i>  | First<br><i>Thomas</i>  | Middle<br><i>Welsh</i>  | Last<br><i>March 13 1959</i>  |                        |                       |
| 4. DATE<br>OF<br>DEATH<br><i>March 13 1959</i>   | Month<br><i>March</i>   | Day<br><i>13</i>  | Year<br><i>1959</i>   |                        |                       |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>white</i>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Sept. 5, 1878</i>  |                        |                       |
| 9. AGE (In years<br>last birthday)<br><i>80</i>  | 10. IF UNDER 1 YEAR<br>Months<br><i>80</i>  | 11. IF UNDER 24 HRS.<br>Days<br><i>0</i>  | 12. IF UNDER 24 HRS.<br>Hours<br><i>0</i>   |                        |                       |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><i>Farmer</i>  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Farm</i>  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |                        |                       |
| 13. FATHER'S NAME<br><i>Jackson Welsh</i>  | 14. MOTHER'S MAIDEN NAME<br><i>Sarah Fisher</i>   |   |   |                        |                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>   | 16. SOCIAL SECURITY NO.<br><i>218-09-3806</i>   | 17. INFORMANT<br><i>Mrs. WM. T. Welsh - Mt. Airy, Md.</i>   | Address   |                        |                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>443x</i> DUE TO <i>Hyperensive + Arteriosclerotic Heart Disease</i>   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><i>4 years</i>   |   |                        |                       |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c)  |   |   |   |                        |                       |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |                        |                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                    |   |   |                        |                       |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.<br><i>19</i>   | 20d. INJURY OCCURRED<br>While<br>at work <input type="checkbox"/> Not while<br>at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)   | 20f. (City or town)<br><i>Mount Airy</i>  | (County)<br><i>Md.</i> | (State)<br><i>Md.</i> |
| 21. I certify that I attended the deceased from <i>Dec 8, 1954</i> to <i>March 13, 1959</i> , that I last saw the deceased alive on <i>March 13, 1959</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br><i>W.B. Culwell</i> |   |   |   |                        |                       |
| ADDRESS (Street, city or town, state)<br><i>Mount Airy, Md.</i> DATE SIGNED<br><i>3/13/59</i>  |   |   |   |                        |                       |
| PHYSICIAN'S<br>NAME (Type)<br><i>W.B. Culwell</i>  |   |   |   |                        |                       |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>  | 22b. DATE THEREOF<br><i>3-16-1959</i>   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Pine Grove</i>   | 22d. LOCATION (City, town, or county)<br><i>Mt. Airy</i> (State)<br><i>Md.</i>                        |                        |                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>C.M. Waltz</i>  | ADDRESS<br><i>Winfield, Md.</i>   | 24a. REC'D BY REGISTRAR<br>DATE<br><i>MAR 16 '59</i>  | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>   |                        |                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

100-10246

DECEASED PERSON'S NAME: **JOHN W. HARRIS**  
DATE OF DEATH: **10-10-1968**  
AGE AT DEATH: **60**  
SEX: **M**  
MATERIAL TESTED: **Whole body**  
TESTS CONDUCTED: **Autopsy**  
TESTS REQUESTED: **None**

TESTS CONDUCTED: **None**  
TESTS REQUESTED: **None**

DEATH CERTIFICATE NUMBER: **100-10246**  
DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE CODE: **None**  
DEATH CAUSE NUMBER: **None**  
DEATH CAUSE DESCRIPTION: **None**  
DEATH CAUSE NUMBER: **None**  
DEATH CAUSE DESCRIPTION: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH DATE: **10-10-1968**  
DEATH TIME: **10:00 AM**  
DEATH PLACE: **100-10246**  
DEATH CAUSE: **Autopsy**  
DEATH CAUSE NUMBER: **None**

DEATH  
DATE

TIME

PLACE

CAUSE

NUMBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03138

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE<br>Maryland  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Brunswick  |   | b. COUNTY<br>Frederick   |  |
| c. LENGTH OF STAY IN 1b<br>Life  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Brunswick 35   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>Souder Road   |   | d. STREET ADDRESS<br>Souder road   |  |
| e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>William   | First<br>B                                    | Middle<br>Wenner   | 4. DATE<br>OF<br>DEATH<br>3 20 Day<br>Month Year<br>1959 |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White                     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br>1-20-1896                            |
| 9. AGE (In years<br>at birthday)<br>83 yrs.  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. | 11. IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Merchant   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Grocery store   |  |
| 11. BIRTHPLACE (State or foreign country)<br>Maryland  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>Charles M. Wenner   |   | 14. MOTHER'S MAIDEN NAME<br>Edna Garrott   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If no or unknown)<br>Yes  |   | 16. SOCIAL SECURITY NO.<br>World 1   |  |
| 17. INFORMANT<br>Mrs. Eleanor Wenner, Brunswick, Maryland  |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>331X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause lost. (b)<br>DUE TO<br>(c)   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>10 min.   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)  |   | 20f. (City or town)<br>(County) (State)  |  |
| 21. I certify that I attended the deceased from March 8, 1959 to March 18, 1959, that I last saw the deceased<br>alive on March 18, 1959, and that death occurred at 12:10 A.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED<br>ACTUAL SIGNATURE <i>C. T. Byron Kao, M.D.</i> M.D. 15 South Maryland Ave. 3-20-59. |   |  |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |   | 22b. DATE THEREOF<br>3-23-1959   |  |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br>St. Marks  |   | 22d. LOCATION (City, town, or county)<br>(State)<br>Petersville, Maryland  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Byron Kao</i>   |   | 24a. REC'D BY REGISTRAR<br>DATE MAR 24 '59   |  |
| ADDRESS<br>Brunswick, Maryland   |   | 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Krause</i>  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03139

Reg. Dist. No.

3145

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br>Maryland  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick-Rural RD#1  |  | c. LENGTH OF STAY IN 1b<br>Minutes   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>Ceresville  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Kensington   |  |
| 3. NAME OF DECEASED (Type or print)<br>First CHARLES Middle OREN Last WILLIAMS  |  | 4. DATE OF DEATH<br>Month March Day 5, Year 19 59  |  |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   | 8. DATE OF BIRTH<br>3 April 1936   |
| 9. AGE (In years<br>last birthday)<br>22 yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  | 11. IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer - Banner Glass   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Company   |  |
| 11. BIRTHPLACE (State or foreign country)<br>North Carolina   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 13. FATHER'S NAME<br>Odell Williams   |  | 14. MOTHER'S MAIDEN NAME<br>Frances Bradley  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>Unk   |  | 16. SOCIAL SECURITY NO.<br>Unk   |  |
| 17. INFORMANT<br>Odell Williams, 305 Smith St.,<br>Address Flint 2, Mich.   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)<br>Fracture Base of Skull<br>DUE TO<br>825X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>Fracture Lt. Parietal Bone<br>DUE TO<br>(c)<br>Fracture of Lower Jaw with multiple lacerations |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | INTERVAL BETWEEN ONSET AND DEATH<br>Instant  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>Automobile Accident  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>1:15 p.m. 3-5, 1959   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)<br>Md. Route 26 & 194 Ceresville-Frederick-Md.   |  |
| 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>B. O. Thomas, M. D.   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | DATE SIGNED<br>5 March 1959  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  | 22b. DATE THEREOF<br>3-6-59  | 22c. NAME OF CEMETERY OR CREMATORIAL<br>ADDRESS<br>M. R. Etchison & Son, Frederick, Maryland   | 22d. LOCATION (City, town, or county) (State)<br>Asheville, North Carolina |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>M. R. Etchison & Son, Frederick, Maryland   | 24a. REC'D BY REGISTRAR<br>MAR 9 '59<br>DATE   | 24b. REGISTRAR'S SIGNATURE<br>Arthur L. Thomas   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03140

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

M

3124

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be added to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                       |  |   |  |                                   |  |            |
|--|-----------------------|--|---|--|-----------------------------------|--|------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Frederick  |                       | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Md.  |                                   | b. COUNTY Frederick  |            |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                       | c. LENGTH OF STAY IN 1b<br>2 yrs.  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Frederick  |                                   | d. STREET ADDRESS<br>168 W. All Saints St.   |            |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>168 W. All Saints Street   |                       |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |  |            |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>Thomas  |                       | First<br>Eugene  | Middle<br>Williams  | 4. DATE<br>OF<br>DEATH<br>March 29   | Month<br>1959                     | Day<br>19  | Year<br>59 |
| 5. SEX<br>M  | 6. COLOR OR RACE<br>C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  | B. DATE OF BIRTH<br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>Feb. 19-1897 | 9. AGE (in years<br>last birthday)<br>62 yrs.  | IF UNDER 1 YEAR<br>Months<br>Days | IF UNDER 24 HRS.<br>Hours<br>Min.  |            |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Chauffeur  |                       | 10b. KIND OF BUSINESS OR INDUSTRY<br>*****   |   | 11. BIRTHPLACE (State or foreign country)<br>Frederick Maryland  |                                   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |            |
| 13. FATHER'S NAME<br>Henry T. Williams   |                       | 14. MOTHER'S MAIDEN NAME<br>Hettie Frazier   |   |  |                                   |  |            |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes   |                       | 16. SOCIAL SECURITY NO.<br>W.W.I 214-16-0409   |   | 17. INFORMANT<br>Marshall Williams - 168 W. All Saints St.   |                                   | Address<br>Frederick, Md.  |            |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>916.0<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate cause<br>(a), stating the underlying<br>cause last.<br>(b)  |                       | Asphyxia from<br>burning mattress  |   |  |                                   | INTERVAL BETWEEN<br>ONSET AND DEATH  |            |
| DUE TO<br>(c)  |                       |  |   |  |                                   |  |            |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                       |  |   |  |                                   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |            |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |                                   |  |            |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. 3/29 1959  |                       | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm,<br>factory, street, office bldg., etc.)<br>Home  |                                   | 20f. (City or town)<br>(County) (State)<br>Frederick Frederick Md.                                   |            |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                       |  |   |  |                                   |  |            |
| ACTUAL<br>SIGNATURE<br>B.O. Thomas   |                       |  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                   | DATE SIGNED<br>3/30/59   |            |
| EXAMINER'S<br>NAME (Type)<br>B.O. Thomas   |                       |  |   |  |                                   |  |            |
| 22a. BURIAL, CREMATION, OR<br>REMOVAL (Specify)<br>Burial  |                       | 22b. DATE THEREOF<br>3-31-59   |   | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Fairview   |                                   | 22d. LOCATION (City, town, or county)<br>(State)<br>Frederick, Md.                                   |            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Charles E. Hicks 111   |                       | ADDRESS<br>Frederick, Md.  |   | 24a. REC'D BY REGISTRAR<br>DATE MAR 31 '59   |                                   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Krause   |            |

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